COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

(b)(2)-2

Why was this person detained? Shooting at [redacted] in Al-fallujah

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.

How was this person traveling (car, bus, on foot)?

Who was with this person?

What weapons was this person carrying?

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information:

ACLU-RDI 1675 p.1

DOD-036617

MEDICAL RECORD | 1 NOV 1800 ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

20 y/o ? Syrian?? c̄ multiple BLE GSW, operated at FST + tx'd. Wounds occurred last nite, arrived FST 0830, op 1230 today

Med, ō allo PMH ⊖

PHYSICAL EXAMINATION

WD ♂ in some pain

HEENT NT ⊖

chest ✓

cv - ō (M)

abd - soft

plv - stable

genital + rectal ⊖

Ext - soft tissue inj (R) buttock near post thigh, +

PROGRESS (Enter date of discharge and final diagnosis)

post (R) leg, small area (L) post thigh

XLNT PT bil, neuro intact, ō DP each side

A - soft tissue inj

P - admit for wound tx

SIGNATURE	DATE	IDENTIFICATION NO.	ORGANIZATION
[redacted]	1 Nov 03		

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility)

(b)(6)-2

[redacted]

(b)(6)-4

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539

GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975 539-106

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
1 Nov, 03	Chief complaint; ? Multiple GSW to legs.
1730	PMH: Ø PSH: Ø All: Ø Meds: Ø Tob: Ø
T: 98.1	Morphine 10 mg IV at 1740 - [redacted] (b)(6)-2
BP: 138/97	
HR: 113	
RR:	
SPO2: 97	

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

USAPA V2.00

2.00

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
1 NOV 03 1930	Received from EMT via stretcher. alert & oriented. IV Ⓛ FA & Ⓛ AC. Ⓛ FA IV patent & intact infusing LR @ 150cc/hr. Ⓛ AC IV d/c with cath intact. Peripheral pulses palpable +2. VSS. Drsg to bilateral lower extremities dry & intact Kerlix drsg. Voiding clear yellow urine via foley cath. Tolerating P.O Fluids. Lungs clear. BS ⊕ x 4 quadrants. Abd soft non distended. Informed pt of NPO status p̄ MN for OR Tomorrow. 2+ restraints applied. Will continue plan of care [redacted] (b)(6)-2
02 NOV 03	(0255) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Pt to OR this am for washout of wounds. Kerlex drsgs to BLEs c̄ small amount sero-sang drainage. Abd drsg pad to buttock c̄ mod amount sero sang drainage. IVFs infusing into IV in Ⓛ forearm s̄ S/Sx infiltration. Foley draining quantity sufficient clear yellow urine. ∅ c/o pain @ this time. +2 pedal pulses equal bilat. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 23044

LAST NAME	[illegible] AME	[illegible]	[illegible] AL [illegible] MBER

DATE	NOTES
02NOV03	(1700) Drsgs to BLE and buttocks reinforced d/t mod. amount sero sang drainage. Pt med. c Percs c good relief of pain. monitoring. [redacted] (b)(6)-2
02 NOV03 2000	VSS. Alert & Oriented. Drsg to Bil LE [illegible] reinforced c combined drsg d/t drsg soiled c serosangious fluids. Pedal pulses papable +2 Toes c capillary refill brisk. (L) FA IV patent & intact infusing LR @ 150cc/hr. Consumed 80% of Regular diet for breakfast. Foley [illegible] draining clear yellow urine Quantity Sufficient. Reposition in bed for comfort. (b)(6)-2 Will Continue care as planned. [redacted]
~~3NOV. 03E 1400~~	~~V.S.S. A&O×3. PT. resting quietly in bed. All DRSGs Δ'd, Silvadine applied to graft sites. W→D DRSNG Δ to (R) LE. Colostomy care done by patient. PT. ambulates s difficulty to BR, and in hallway. J-tube D/C'd by MD this AM. DRY DRSNG applied. PT. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL.~~ (ERROR) [redacted] (b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 23045

ACLU-RDI 1675 p.5

DOD-036621

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
3NOV03 @ 1800	Pt. A&O x3. V.S.S. Pt. given 2mg MSO4 for pain prior to
	DRSNG Δ. Pt. had W→D DRSNG Δ's to multiple LSNS
	to LE bilat & (L) buttocks, wrapped c̄ Kerlex, moderate
	sero-sang. drainage to wounds, penrose drains intact. LR
	infusing to (L) forearm @ 150cc/h. Foley to gravity, light
	clear urine. Pt. in 2-point restraints, Ø signs of skin (b)(6)-2
	breakdown. All other assessments WNL. [redacted]
3NOV03	assumed care of pt @1800. VSS. Pt in bed c/o pain, Relieved
@2245	c̄ Percocet. (R) thigh, (L) thigh, & buttocks drsgs CDI.
	(L) FA IV H/S, tol po well. LS CTA, Foley draining
	yellow urine QS. Plan: cont IV abx as ordered,
	monitor neurovasc status to BIL leg, pain
	control. 2pt restraints in S/S/Sx of skin or
	circulation compromise. Will monitor. neurovasc
4NOV03	Pt voided approx 2000cc this shift per foley. [redacted] (b)(6)-2
@0600	CDI.
04NOV03	(1015) Assumed care @ 0800. Pt alert, speaking Arabic.
	VSS. Pt medicated c̄ II Percs prior to drsg Δ - tol.
	well. Drsgs to BLE Δd, wounds packed WTD. Pen
	rose drains intact draining sm. amount sero.
	sang drainage. Sutures intact to BLE. [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)	REGISTER NO.	WARD NO.
[redacted] (b)(6)-4		

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.(

MEDCOM - 23046

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
Ø4NOVØ3 (1Ø2Ø)	(cont.) drain to Ⓛ buttock intact. Φ S/Sx infection @ wound sites. Pt moves well in bed. SL in Ⓛ forearm flushes well s̄ S/Sx infiltration/infection. Pt tol. reg diet well. Foley draining quantity sufficient clear yellow urine. 2-point restraints in place s̄ S/Sx complications. Will cont. to monitor. [redacted] (b)(6)-2
	(1745) Foley d/c'd this pm. Pt aware he is DTV in urinal by 2Ø15. Pt OOB to amb in hallway c̄ assist of walker. Pt favors Ⓡ leg, but amb c̄ steady gait. medicated c̄ ӀӀ Perc prior to amb - tol. well. Monitoring. [redacted] (b)(6)-2
4NOV03 @2015	assumed care of pt @1800. VSS, no C/o. alert, LSQA, ⊕BS, tol reg diet & po pain meds well; ⊕ void approx 2000ml of 600cc clear/yellow urine. BLE & Ⓛ buttocks drsgs CDI; ⊕ cms to BLE. Ⓛ FA heplock flushes well, IV Abx given as ordered. 2pt restraints on s̄ S/SX skin/circulation compromise. Plan: monitor drsgs, pain control, IV Abx. [redacted] (b)(6)-2
Ø5NOVØ3	(Ø915) Assumed care @ Ø6ØØ. Pt alert, speaking Arabic. VSS. Φ C/O pain. Pt OOB to chair. Personal hygiene

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

[redacted] (b)(6)-2

REGISTER NO. | WARD NO. CW1

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 23047

ACLU-RDI 1675 p.7

DOD-036623

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
05NOV03	(cont) done by pt c̄ min. assist from staff. Pt amb in hallway c̄ assist of walker - tol. well. Gait steady - pt placing pressure on BLE. Drsgs to BLE/buttock c̄ mod. amount serosang drainage. Awaiting MD for drsg Δs per his request. SL in Ⓛ forearm flushes well s̄ S/sx infection/infiltration. Pt eating breakfast in chair @ this time. Will continue to monitor. [redacted] (b)(6)-2
	(1315) Drsgs to BLE/buttock Δd. Penrose drains intact draining sm. amount sero-sang drainage. WTD drsg applied to multiple GSWs. ф S/sx infection. Will cont. to monitor. [redacted] (b)(6)-2
5NOV03@ 2330	assumed care of pt @1800. VSS. C/o pain to RLE, percocet given c̄ good relief noted. Alert, understands English. LSCTA; ⊕BS, tol po well; voids s̄ difficulty to urinal. Pt ↑ AMB to BR c̄ walker. Ⓛ buttocks & BIL LE drsgs reinforced D/t ↑ serosanguinous drainage. 2pt restraints on s̄ S/sx of skin/circulation compromise. Plan: monitor drsgs, pain control, IV Abx as ordered. Will monitor. [redacted]
6 NOV Ø3 (11Ø5)	Pt a/o, VSS, premedicated c̄ 5mg MSO4 for drsg Δ. mod. serous drainage noted to Ⓡ thigh wound. scant drainage to all other wounds. packed c̄ WTD gauze & wrapped c̄ Kerlix. MD @ BS during drsg Δ. Penrose drains removed by MD (Dr Davis). Pt voiding s̄ difficulty via urinal. ⊕ peripheral pulses. HL Ⓛ wrist flushing easily. Plan: monitor

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.0

(b)(6)-4 [redacted]

MEDCOM - 23048

ACLU-RDI 1675 p.8

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MEDICAL RECORD | **PROGRESS N[illegible]S**

DATE	NOTES
	6 Nov [redacted] (b)(6)-2
	Wound cleaning [illegible] removed, pt ambulatory
	P- [illegible]
	[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME			SPONSOR'S ID NUMBER (SSN or Other)
	LAST	FIRST	MI	

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199[illegible]
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1[illegible]
USAPA V1.0

MEDCOM - 23049

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6Nov@1105 (cont)	drsg's, ambulate, pain control + IV ABX per MD orders. Will monitor [redacted]
6NOV 2340	VSS. ↓ BP 97/46. Will continue to monitor BP. Pt denies (b)(6)-2 any pain. Prior to DSG Δ's, premed c̄ 5mg MSO4. Completed DSG c̄ WTD NS soaked gauze, + kerlix wrap. (L) LE sutures (-) s/sx of infection. Well approximated x̄ for superior portion of suture. Serosanginous drainage from area 2° ↓ approximation. (R) upper thigh DSG had mod. amt serosanginous drainage. Sutures approximated x̄ ↓ approximation to ~~sutures~~ medial sutures. Packed openning c̄ NS soaked gauze. Pt attempted to amb however only stood at side of bed 2° ↑ pain. Pt requires assistance OOB + vice versa. Voiding in urinal s̄ difficulty. 2 pt restraints s̄ compromise to skin. Pt able to move toes, (+) pedal pulses B/L, (+) cap. refill B/L. Plan: Cont IV ABX, WTD DSG, Amb as tolerated. [redacted] (b)(6)-2
7 NOV 03 (1140)	Pt alo VSS, ø complaints, drsgs Δ'd. (premedicated). (R) calf c̄ mod amt bloody drainage. (R) thigh wound (largest) c̄ sero-sang drainage. Wounds packed c̄ NS soaked gauze and wrapped c̄ Kerlix. → (cont)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

[redacted] (b)(6)-4

MEDCOM - 23050

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7NOV @ 1140	(cont) Pt ambulated around room c̄ walker (requires assistance). OOB to chair for 60 min. ⊕ pedal pulses, brisk cap refill. Ancef cont. voiding qs via urinal. 2 pt restraints on while in bed. ⊘ compromise to skin or circulation will monitor.
8NOV @ 0005	VSS, Temp slightly elevated. Will continue to monitor. Completed DSG Δ's to B/L LE. WTD. ⊕ pedal pulses B/L ⊕ cap Refill B/L. Mod amt of serosang drainage noted on Ⓡ buttock, Ⓛ calf, Ⓡ calf. Pt tol. ~~DSG~~ DSG Δ well. Premedicated c̄ 5mg MSO4 IV. Pt Refused dinner, Pt has IV ABX infusing. Voiding in urinal s̄ difficulty. Pt asleep at this time. (b)(6)-2
8NOV 03 0700	- Assumed care of pt, VSS ⊘ c/o pain or discomfort. Multiple GSW to BLE and butt. wet to dry dsg intact minimal active bleeding serous drainage to dsg 5mg premedicat MS for dsg change. Lungs clear HRRR Urinate spontaneously per urinal Cont IV ABX Tx Remains afebrile Will cont to monitor (b)(6)-2
8NOV.03 2000	Pt A+OX3, VSS, LS CTA Ⓑ, ⊕ BSx4, multiple dsg on LE x2, W→D dsg, ⊘ s/sx of infex, blood drainage noted on old dsg's, wounds beefy red, medicated c̄ i perc, tol well IV SL Ⓛ FA intact, ⊘ s/sx of infex, cont IV abx, ate most of diet, voiding s̄ diff per urinal, 2 point restraint, ⊘ complications.

STANDARD FORM 509 (REV. 5/1999) BA
(b)(6)-2
USAPA V1

(b)(6)-4

MEDCOM - 23051

AUTHORIZED FOR LOCAL REPRODUCTIO

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9 Nov 03	D/C Summary:
	Pt admitted 1 November with multiple gun shot wounds
	① both lower extremities, all soft tissue - no fracture or neuro vascular
	impairment. Pt taken to surgery and wounds debrided and partially
	closed, penrose drains left in place til 5th day then removed and
	saline wet to dry dressing continued. Wounds are clean and pt is
	ambulatory
	Pt has Ⓡ buttock wound, will need stitch removal on
	10th - 14th day, also on Ⓛ calf. Wet to dry dressing to continue til
	wounds have granulated, will heal spontaneously with time or graft
	could be done at later date.
	[redacted] (b)(6)-2
	[redacted] (b)(2)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/199
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(1
USAPA V1.0

E # [redacted] (b)(6)-4

MEDCOM - 23052

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
	2 Nov Op note
	Debridement / irrigation of (R) buttock
	(R) medial thigh + (R) calf wound
	(L) buttock + (L) calf wound
	1100 EBL 100
	[redacted]
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23053

ACLU-RDI 1675 p.13

DOD-036629

MEDICAL RECORD — **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-407, the prop g is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATIN OM VIA litter BY anesthesia

2. PATIENT IDENTI CORD REVIEWED AND PROCEDURE VERIFIED BY [redacted]

3. DATE 2NOV03 TIME PATIENT ARRIVED IN SUITE —

4. PATIENT IN ROOM TIME 0910 NUMBER 1-1 (b)(6)-2

5. PREOPERATIVE EMOTIONAL STATUS

[X] CALM [ ] ANXIOUS [ ] EXCITED [ ] CRYING [ ] ANGRY [ ] WITHDRAWN [X] OTHER *(Specify)*

COMMENTS: Pt not english speaker.

6. NURSING PERSONNEL

ASSIGNED SCRUB	PFC	RELIEF SCRUB	
ASSIGNED CIRCULATOR	[redacted] (b)(6)-2	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)* Pt prone. padded rolls placed under chest. Bilateral arms on padded arm boards. Pillows under knees and legs.

[ ] SUPINE [ ] LITHOTOMY [X] PRONE [ ] KRASKE LATERAL: [ ] LEFT SIDE UP [ ] RIGHT SIDE UP

COMMENTS: Pt positioned by [redacted] (b)(6)-2

8. SKIN PREPARATION

HAIR REMOVAL [X] YES [ ] NO [redacted]
DONE BY: [X] OR [ ] NURSING UNIT (b)(6)-2
METHOD: [ ] DEPILATORY [X] RAZOR [ ] CLIP

COMMENTS: no nicks or cuts noted.

PREP SOLUTION *(Specify)* Beta/Beta
SITE: (L) leg BY WHOM:
SITE: (R) leg to hip. BY WHOM: [redacted]

COMMENTS: no pooling of prep noted. (b)(6)-2

9. LOCATION OF EXTERNAL DEVICES

padded rolls
pillows

LEGEND X [redacted] Pad -- [redacted] rap === Tourniquet XX - prep

needle - 2
blades - 2

10. COUNTS — C = Correct I = Incorrect

			Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	[X] Yes	[ ] No	C	/	C	[redacted]	[redacted]
Needle Sharp	[X] Yes	[ ] No	C	/	C		
Instrument	[ ] Yes	[X] No				(b)(6)-2	(b)(6)-2
Other	[ ] Yes	[X] No	/	/	/		

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

EPW # [redacted] (b)(6)-4

[redacted] (b)(2)-2

2NOV03

12. ELECTROSURGERY DEVICE(S) (ESU) [X] YES [ ] NO

CUT 45 COAG 45

[X] ESU NO: Valleylab E7507
GROUND PAD: BRAND Valleylab
LOT NO: 65706 2004-11

[ ] ESU NO:
GROUND PAD: BRAND
LOT NO:

[ ] BIPOLAR NO:

DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.00

MEDCOM - 23054

13. PROSTHESIS, IMPLANTS ☐ NO IF YES NAME: ID NUMBER; FACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):
D.9% NACL

OTHER ORDERS	TIME	CARRIED OUT BY
~~16F Foley to gravity by [illegible]~~	~~[illegible]~~	[redacted] (b)(6)-2

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☐	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☐	NAME	NAME
CULTURE (C) YES ☐ NO ☐	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	1" Penrose		
SITE	buttocks		

18. DRESSING/IMMOBILIZATION *(Specify)*
- fluffs
- Kerlix
- Xeroform

19. ADDITIONAL INFORMATION
surgeon: Dr [redacted] (b)(6)-2

anesthesia:
Maj. [redacted] (b)(6)-2

20. OPERATION(S) PERFORMED
I & D lower extremity wounds.

21. PATIENT TRANSFERRED TO ICU TIME 1100 METHOD litter

22. REGISTERED NURSE SIGNATURE [redacted] CPT/AN

REVERSE O[redacted] MEDCOM - 23055 USAPA V1.00

(b)(6)-2

511-119 NSN 7540-00-634-4124

MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY									
POST- DAY									
MONTH-YEAR / DAY	1 NOV	02	NOV 3	04	05	06	7		
19 / HOUR									

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE: 120/59 134/70 123/61 108/47 110/48 131/61 124/60 124/60 120/64 120/60 97/46 123/59 114/60
120/68 113 109 118/50 122/70 107
99.8 99.9 124/59 127/68 100.3 98.6
97% 98% 98%

HEIGHT: WEIGHT →

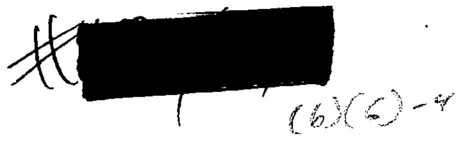
Record special data only when so ordered

025197 98 98 98(RA) 99(RA) 98% 97(RA) 98% RA 97%
98(RA) 97(RA) 98%
98(RA) 98(RA) (RA) Pulse 99
118/68

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. ICW#1



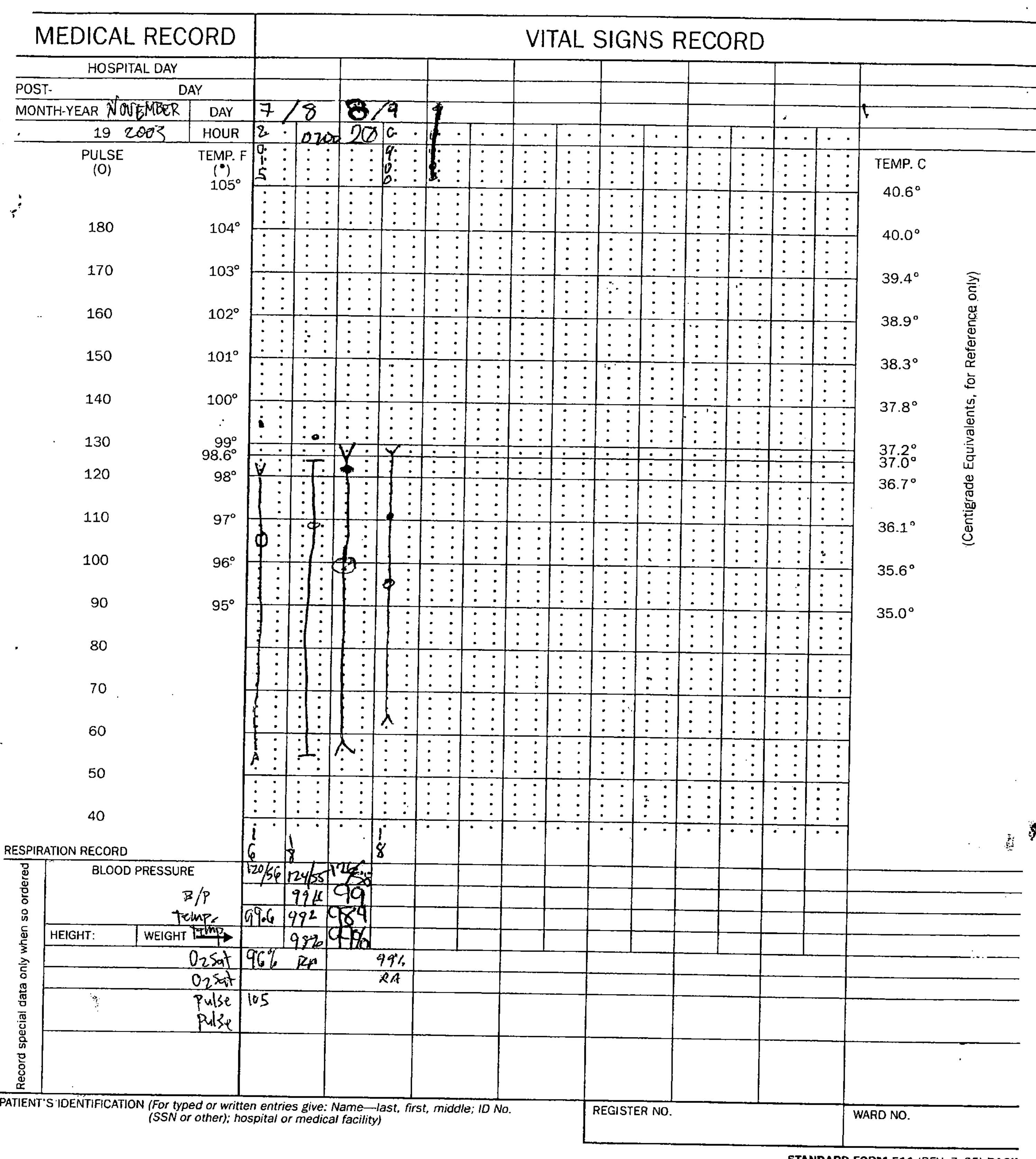
(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23056



MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOVEMBER DAY 7/8 8/9

19 2003 HOUR 2015 0700 2000

PULSE (O) TEMP. F (•)

RESPIRATION RECORD

BLOOD PRESSURE 120/56 124/55

B/P

Temp. 99.6 992 984

HEIGHT: WEIGHT Temp 98%

O2Sat 96% RA 99% RA

O2Sat

Pulse 105

Pulse

Record special data only when so ordered

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO.

WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

MEDCOM - 23057

ACLU-RDI 1675 p.17

DOD-036633

Ward/Section: EMT | REQUESTED BY: Dr [redacted] (b)(6)-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] | DATE: 1 Nov | TIME: 1735 | SSN/PSEUDO SSN: [redacted]

(Hematology) CBC (b)(6)-4

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ke		
SG		
Bld		
pH		
Pr		
Ur		
Ni		
Le		
Hi		
Ce Co		
Directi		

(b)(6)-4

ID: [redacted]
WB
01-11-03
17:50
Patient Limits

WBC	7.2	x10^3/uL	4.5	10.5
RBC	3.14 L	x10^6/uL	4.00	6.00
Hgb	9.2 L	g/dL	11.0	18.0
Hct	29.0 L	%	35.0	60.0
MCV	92.3	fL	80.0	99.9
MCH	29.4	pg	27.0	31.0
MCHC	31.8 L	g/dL	33.0	37.0
Plt	198.	x10^3/uL	150.	450.
LY%	16.0 *L	%	20.5	51.1
LY#	1.1 *L	x10^3/uL	1.2	3.4

Misc. Serology (b)(6)-4

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

MEDCOM - 23058

Ward/Section: EMT | REQUESTING PHYSICIAN: Dr [redacted]

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI: [redacted] (b)(6)-4 | DATE: 1 Nov | TIME: 1735 | SSN/PSEUDO SSN: [redacted] (b)(6)-4

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANG
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

```
======= PICCOLO =======
01/11/03            18:06
REFERENCE RANGE:     MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #:        3325AA4
OPER #: [redacted]   DR #: 000
SERIAL #: [redacted]
.............................
GLU    121*   73-118    MG/DL
BUN    9      7-22      MG/DL
CA++   7.7*   8.0-10.3  MG/DL
CRE    0.7    0.6-1.2   MG/DL
NA+    140    128-145   MMOL/L
K+     5.2*   3.3-4.7   MMOL/L
CL-    102    98-108    MMOL/L
tCO2   25     18-33     MMOL/L

INST QC: OK    CHEM QC: OK
HEM 0 , LIP 0 , ICT 0
```

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

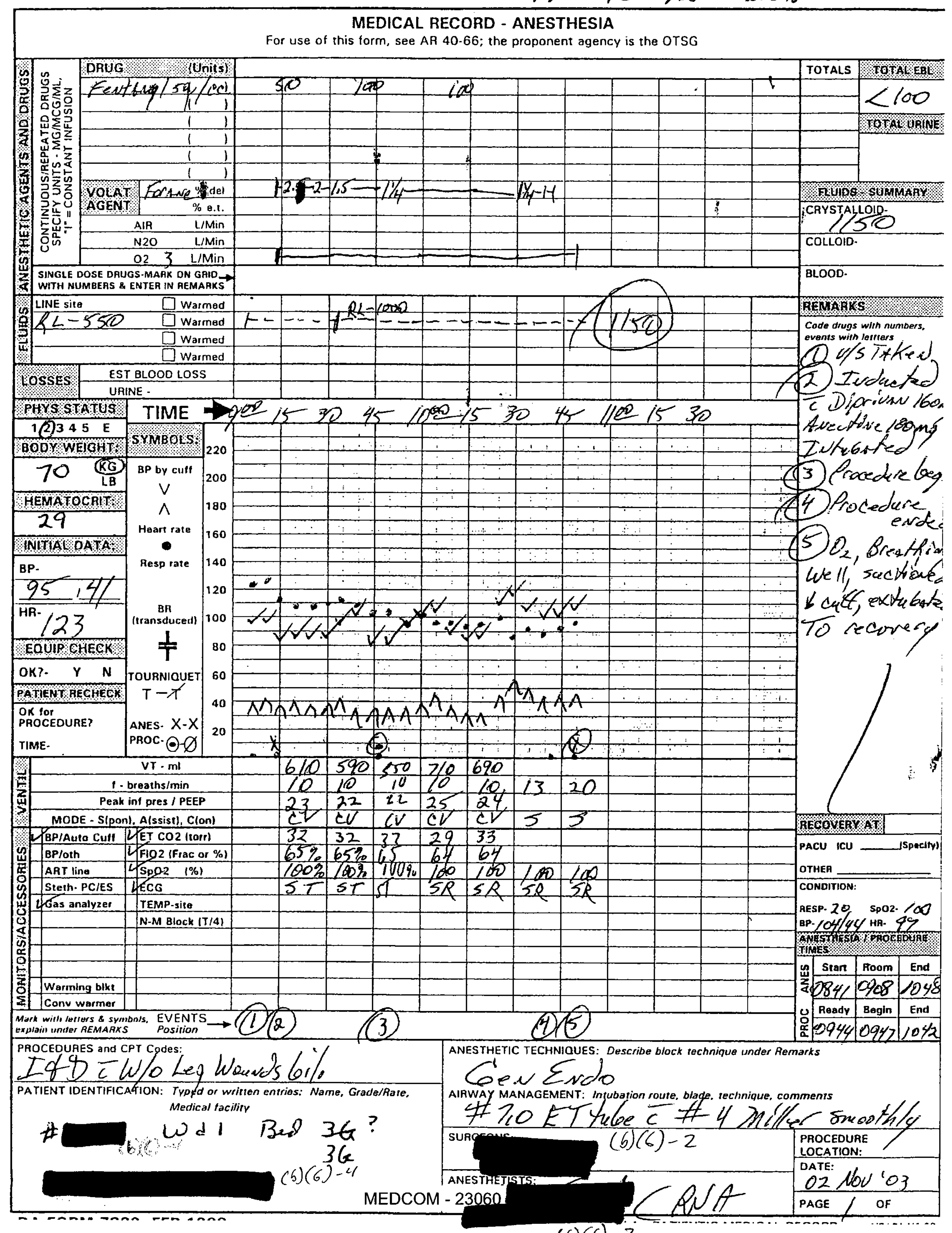
REPORTED BY: | DATE: | LAB ID NO.:

MEDCOM - 23059

21 y/o ? [illegible] ♂ 11/1 9.2 / 29.0 198 140 / 5.0 102 / 25 9 / 1.7 121 Ca

Ancef

NKDA 11/1 Hx [illegible] (B) ↓ ext [illegible] 98.6 – 90 120/68 SaO2 58%



MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS — CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)					
Fentanyl / 50 / cc	50	100		100	
VOLAT AGENT Forane % del	1.2 – 2 – 1.5 — 1¼ —			1¼ – 1	
% e.t.					
AIR L/Min					
N2O L/Min					
O2 3 L/Min					

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

TOTALS — TOTAL EBL: < 100 — TOTAL URINE:

FLUIDS - SUMMARY
CRYSTALLOID- 1150
COLLOID-
BLOOD-

FLUIDS — LINE site: RL-550 ☐ Warmed; RL-1000 … (1150)

LOSSES — EST BLOOD LOSS; URINE -

PHYS STATUS: 1 (2) 3 4 5 E

TIME: 900 15 30 45 1000 15 30 45 1100 15 30

BODY WEIGHT: 70 KG

HEMATOCRIT: 29

INITIAL DATA: BP- 95/41 HR- 123

EQUIP CHECK OK?- Y N

PATIENT RECHECK OK for PROCEDURE? TIME-

SYMBOLS: BP by cuff V Λ; Heart rate ●; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X–X; PROC- ⊙–Ø

REMARKS — Code drugs with numbers, events with letters
1. U/S taken
2. Inducted c̄ Diprivan 160, Anectine 180mg Intubated
3. Procedure beg
4. Procedure ended
5. O2, Breathing well, suctioned ↓ cuff, extubated To recovery

VENTIL

VT - ml	610	590	550	710	690		
f - breaths/min	10	10	10	10	10	13	20
Peak inf pres / PEEP	23	22	22	25	24		
MODE - S(pon), A(ssist), C(on)	CV	CV	CV	CV	CV	S	S

MONITORS/ACCESSORIES

✓ BP/Auto Cuff	✓ ET CO2 (torr)	32	32	33	29	33		
BP/oth	✓ FIO2 (Frac or %)	65%	65%	65	64	64		
ART line	✓ SpO2 (%)	100%	100%	100%	100	100	100	100
Steth- PC/ES	✓ ECG	ST	ST	ST	SR	SR	SR	SR
✓ Gas analyzer	TEMP-site							
	N-M Block (T/4)							
Warming blkt								
Conv warmer								

Mark with letters & symbols, explain under REMARKS — EVENTS Position: (1) (2) (3) (4) (5)

RECOVERY AT — PACU ICU ____ (Specify) OTHER ____
CONDITION: RESP- 20 SpO2- 100 BP- 104/44 HR- 97

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0841	0908	1048
	Ready	**Begin**	**End**
PROC	0944	0947	1042

PROCEDURES and CPT Codes: I&D c̄ W/o Leg Wounds b/l

ANESTHETIC TECHNIQUES: Describe block technique under Remarks — Gen Endo

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility — # [redacted] Wd 1 Bed 3G ? 3G [redacted] (b)(6)-4

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments — #7.0 ET tube c̄ #4 Miller smoothly

SURGEONS: [redacted] (b)(6)-2

ANESTHETISTS: [redacted] CRNA (b)(6)-2

PROCEDURE LOCATION:

DATE: 02 Nov '03

PAGE 1 OF

MEDCOM - 23060

DA FORM 7389, FEB 1999

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS | LIST TIME ORDER NOTED AND SIGN

Admit ICW
Cond stable
Diet - reg
Act - ad lib
VS - q4h
Dx - soft tissue wound
IV LR at 150 cc/h

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER | TIME OF ORDER | HOURS

[illegible]
NPO p MN for OR washout
2 Nov
Percocet 2 po q4 prn til MN
then 5 mg MS IV q1-2h prn pain

Noted [illegible] 1915 1 NOV

PATIENT IDENTIFICATION

DATE OF ORDER | TIME OF ORDER | HOURS

Ancef 1gm IVPB q8h
XR pelvis (L) femur / tib/fib
(R) " "
tet toxoid
1/2 cc IM

NURSING UNIT | ROOM NO. | BED NO.

2 NOV 1000

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER | TIME OF ORDER | HOURS

(1) Resume preop orders
(2) Reg diet

Noted [illegible] 2 NOV 03 1130

NURSING UNIT | ROOM NO. | BED NO.

4 W

(b)(6)-2

DA FORM 4256, 1 APR 79 — [illegible] MEDCOM - 23061 [illegible] MAY BE USED.

ACLU-RDI 1675 p.21

DOD-036637

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

noted

(b)(6)-2

DATE OF ORDER: 3NOV03 TIME OF ORDER: 2000 HOURS

LIST TIME ORDER NOTED AND SIGN

1. HL IV.

V.O. DR (b)(6)-2 / (b)(6)-2

NURSING UNIT: ICW#1 ROOM NO.: 24° 0252 BED NO.: 4NOV03

PATIENT IDENTIFICATION

DATE OF ORDER: 4 Nov 1700 TIME OF ORDER: HOURS

1. DC foley
2. Ambulate

Noted (b)(6)-2

4NOV03

(b)(6)-2

NURSING UNIT: 24° / 2345 4Nov ROOM NO. BED NO.: 1335

PATIENT IDENTIFICATION

(b)(6)-4

noted (b)(6)-2

DATE OF ORDER: 6NOV03 TIME OF ORDER: 1000 HOURS

1. BID drsg Δ's to (B) LE & (L) buttock (WTD) & wrap c̄ Kerlix.

(b)(6)-2 (b)(6)-2

V.O. Dr (b)(6) / SPC (b)(6)

24° (b)(6) [illegible] AN 7NOV@0130

NURSING UNIT: ICW#1 ROOM NO.: 6NOV03 BED NO.: 1010

PATIENT IDENTIFICATION

(b)(6)-4

DATE OF ORDER: 9 NOV 03 TIME OF ORDER: 0900 HOURS

1. D/C ANCEF IVPB
2. D/C IVSL

V.O. DR. (b)(6)-2 / (b)(6)-2 2 LT, AN

NURSING UNIT ROOM NO. BED NO.

DA FORM 4256, 1 APR 79 — REPLAC[ES] MEDCOM - 23062 [WHIC]H MAY BE USED.

ACLU-RDI 1675 p.22

DOD-036638

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
[redacted] (b)(6)-4		6 Nov '03 1200 HOURS	1550 6 Nov 03 [redacted] (b)(6)-2
		Chg drsg q12h NS soaked gauze	
		[redacted] (b)(6)-2	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER / TIME OF ORDER ______ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 4256 REPLAC[ES] ... MEDCOM - 23063 ...H MAY BE USED.

ACLU-RDI 1675 p.23

DOD-036639

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 1	2	3	04	05	06	07	8	9				
1	[redacted]	Diet: regular	6													
			18													
1	[redacted]	VS: Q4°	6													
			18													
1	[redacted]	Foley to gravity	6					DC 01 OCT 03								
			18													
04 OCT 03	[redacted]	Ambulate	06 18	/	/	/										
			18 06	/	/	/										
6 NOV 03	[redacted]	WTD drsg Δ's to (B)	10	→												
		LE & (L) buttock &	22	→												
		wrap c Kerlix BID	X													
6 NOV 03	[redacted]	Δ drsg q 12 hr NS	10	→				/								
		soaked gauze	22	→				/								

(b)(6)-2

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: soft tissue wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO: ____

PATIENT IDENTIFICATION: [redacted]

(b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

MEDCOM - 23064

Verity by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 11	Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
1	[redacted]	admit ICW#1, stable	Ø1	—	—	[redacted]
1	[redacted]	NPO p̄ MN for OR washout 2NOV	1NOV	2400	—	[redacted]
1	[redacted]	XR pelvis (L) femur/tib/fib	1Nov	[redacted]	[redacted]	[redacted]
	----	(R) femur/tib/fib				
Ø2 NovØ3	[redacted]	Resume pre-op orders	Ø2	—	—	[redacted]
Ø4 NovØ3	[redacted]	D/C foley	Ø4 OCTØ3	—	1415	[redacted]

	----					

b(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
----	----		
----	----		
----	----		
----	----		
----	----		
----	----		
----	----		
----	----		
----	----		
----	----		

USAPA V1.00

MEDCOM - 23065

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 11 *Yr.* 03

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 1	2	3	04	05	06	07	08	09					
1	[redacted]	LR @ 150cc/hr	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
			18	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]						
1	[redacted]	Ancef 1gm IVPB	6	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]					
		Q8°	14	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]		(6)(6)-2					
			22	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
4	[redacted]	N:HL	6			[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							
			18	/	/	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]							

ALLERGIES: ☐ YES ☐ NO

PRIMARY DIAGNOSIS: soft tissue wound

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO

PAGE NO. ________

PATIENT IDENTIFICATION:

[redacted] (6)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 1 FEB 79 4678 EDITION MEDCOM - 23066 TIL EXHAUSTED.

. Verify by Initialing	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)	Mo. 11 Yr. ϕ3

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
1	[redacted]	Toxoid 1/2cc IM	1 NOV	—	2 NOV 0400	[redacted] (b)(6)-2

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED													
1	[redacted]	PERCOCET ii po Q4° prn pain until MN	D/T	02NOV 1700	3NOV 2030	04NOV 0830	04NOV 1630	5NOV 0915	05NOV 1040	5NOV 2000	8NOV 1830	8NOV 2200	9NOV 0142			
		then 2	D/I	ii	ii	ii	ii	ii po	ii	ii po	ii	ii	ii	(b)(6)-2		
1	[redacted]	MSO4 5mg IV Q1-2H prn pain	D/T	2NOV 0330 5mg	2NOV 0530 5mg	3NOV 1420	6NOV 2000 5mg IM	6NOV 2130 5mg/hr		6NOV 1000	7NOV 1920	7NOV 2045	8NOV 0415	8NOV 1000	9NOV 1100	
			D/I	[initials]	[initials]	[initials]				5mg	5mg	5mg	5mg	5mg	5mg	
														(b)(6)-2		

*U.S. GPO: 1998-454-110/95216

MEDCOM - 23067

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General.

REPORT TITLE: Post-Anesthesia Care Unit (PACU) Flow Sheet

OTSG APPROVED (Date)

Date: 2 NOV 03
Time In: 1035
Allergies: NKDA
Pre-op V/S: 93/41 123
Procedures: [illegible]
Anesthesia Type (Circle): (General) Spinal Epidural IV Sedation Nerve Block
OR Intake: Crystalloid 1150 Colloid
OR Output: UOP EBL [illegible]
Meds/Times: [illegible]

Drains: Hemovac, NG, JP, T-tube, (Foley), TLS

Airway: Nasal, ~~Oral~~, ETT, Trach, Other

Pre Op Meds

History

Time	1035	1050	1055	1110	1120
SaO2	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
FIO2					
Methods	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
RR	[illegible]	[illegible]	13	[illegible]	[illegible]
T	[illegible]				

Scale: 240, 220, 200, 180, 160, 140, 120, 100, 80, 60, 40, 20

Pacu Intake

Time	Solution	Amount	Site	By	Infused
1045	LR	400	[illegible]	[illegible]	600

X-rays:

Labs:

Post-Anesthesia Recovery score

Criteria	ADM	30'	D/C
Activity (2) Moves 4 Extremities (1) Moves 2 Extremities (0) Moves 0 Extremities	1	2	2
Airway (2) Cough, Deep breath (1) Dyspnea, limited breathing (0) Apnea	1	2	2
Blood Pressure (2) SBP =/- 20 of Pre-op (1) SBP =/- 20-50 of Pre-op (0) SBP =/- 50 of Pre-op	2	2	2
Consciousness (2) Fully Awake, audible crying (1) Arousable to verbal or pain	1	1	1
Color (2) Baseline color & appearance (1) pale, mottled, jaundiced (0) Cyanotic	2	2	2
Circulation (Peds < 5 Years) (2) radial Pulse Palpable (1) Axillary palpable, not radial (0) Carotid only reliable pulse			
TOTALS: Must be 9 or greater to D/C, otherwise needs anesthesia approval for D/C.	7	9	9

Codes

AIRWAY: A = Ambu, BB = Blow-by, M = Mask, FT = Face Tent, RA = RoomAir, NC = Nasal Cannula

V/S: X = A-line BP, ˇ = Cuff BP, ˙ = Pulse

TEMP: S = Skin, O = Oral, A = Axillary, T = Tympanic, R = Rectal

LOS: C = Cervical, T = Thoracic, L = Lumbar, S = Sacral

Time							Patient teaching done: Wound Care, Pain Management,
Pain (0-10)		4					T, C, & DB,. Incentive Spirometer, Comfort Measures
LOS							Safety: SR up X 2, Falls Precautions. Privacy Maintained

(Continue on reverse)

PREPARED BY (Signature & Title): [redacted] (b)(6)-3 [illegible]

DEPARTMENT/SERVICE/CLINIC: PACU

DATE: 2 NOV 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name — last, first, middle; grade; date; hospital or medical facility)

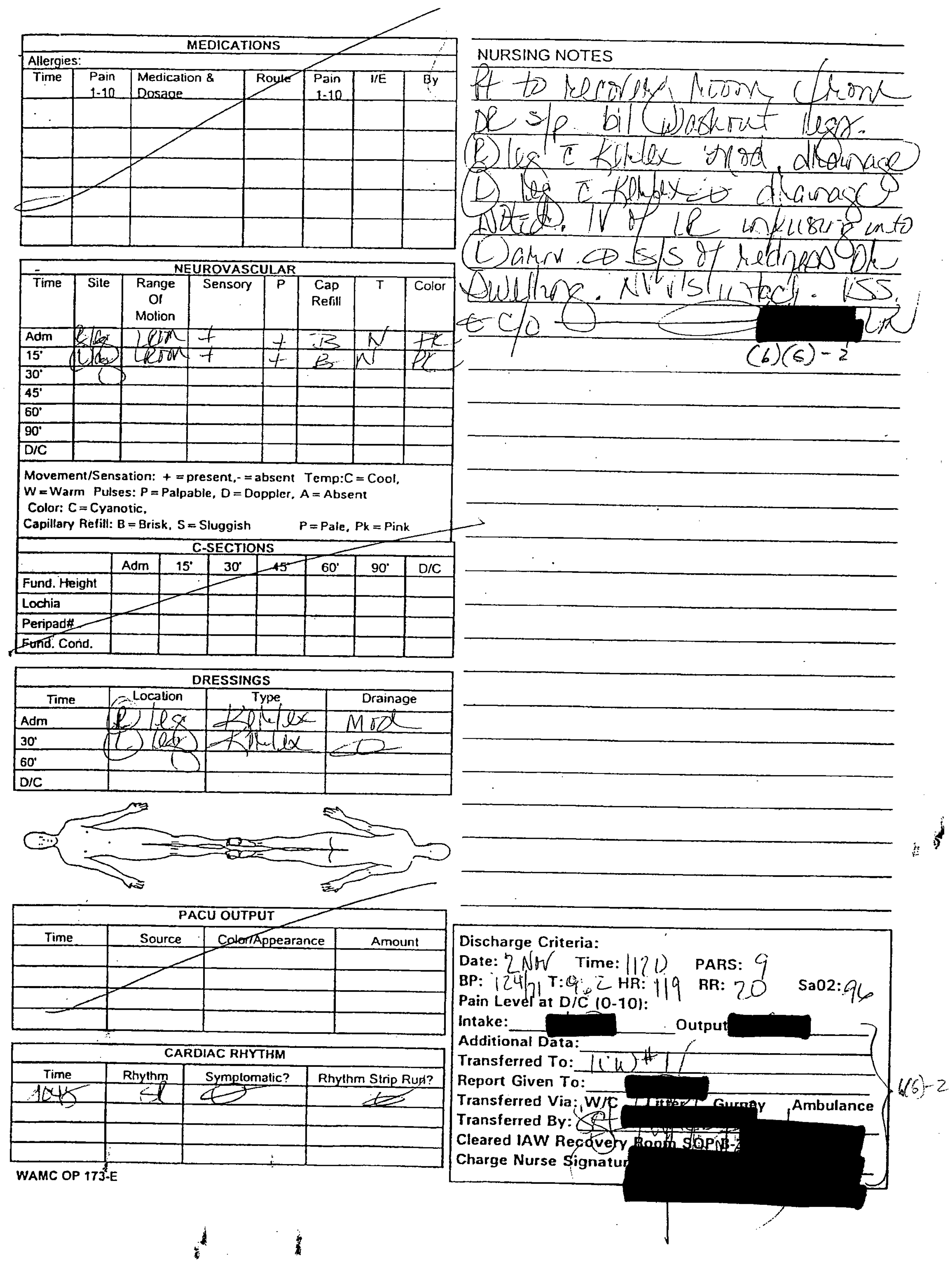
EPW # [redacted] (b)(6)-4

☐ HISTORY/PHYSICAL
☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION
☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 4700, MAY 78 — WAMC OP 173-E, (Revised) 1 Apr 01 (MCXC-DN) — Previous edition is obsolete

MEDCOM - 23068

USAPPC V2.00



MEDICATIONS

Allergies:

Time	Pain 1-10	Medication & Dosage	Route	Pain 1-10	I/E	By

NEUROVASCULAR

Time	Site	Range Of Motion	Sensory	P	Cap Refill	T	Color
Adm	(R) leg	ROM	+	+	B	W	PK
15'	(L) leg	ROM	+	+	B	W	PK
30'							
45'							
60'							
90'							
D/C							

Movement/Sensation: + = present, - = absent Temp: C = Cool, W = Warm Pulses: P = Palpable, D = Doppler, A = Absent Color: C = Cyanotic, P = Pale, Pk = Pink Capillary Refill: B = Brisk, S = Sluggish

C-SECTIONS

	Adm	15'	30'	45'	60'	90'	D/C
Fund. Height							
Lochia							
Peripad#							
Fund. Cond.							

DRESSINGS

Time	Location	Type	Drainage
Adm	(R) leg	Kerlex	Mod
30'	(L) leg	Kerlex	⌀
60'			
D/C			

PACU OUTPUT

Time	Source	Color/Appearance	Amount

CARDIAC RHYTHM

Time	Rhythm	Symptomatic?	Rhythm Strip Run?
1045	ST	⌀	⌀

WAMC OP 173-E

NURSING NOTES

Pt to recovery room from OR s/p bil washout legs. (R) leg c Kerlex mod drainage (L) leg c Kerlex ⌀ drainage noted. IV of LR infusing into (L) arm ⌀ s/s of redness or swelling. NVS intact. VSS. c/o ⌀ [redacted]

(b)(6)-2

Discharge Criteria:

Date: 2 Nov Time: 1120 PARS: 9

BP: 124/71 T: 99.2 HR: 119 RR: 20 Sa02: 96

Pain Level at D/C (0-10):

Intake: [redacted] Output [redacted]

Additional Data:

Transferred To: ICW #1

Report Given To: [redacted]

Transferred Via: W/C Litter Gurney Ambulance

Transferred By: [redacted]

Cleared IAW Recovery Room SOP [redacted]

Charge Nurse Signatur[redacted]

(b)(6)-2

MEDCOM - 23069

ADMISSION AND CODING INFORMATION

For use of this form, see AR 40-400; the proponent agency is OTSG

1. REPORTING MTF: 1 2 3 4 5 6 — A 1 1 0 1
2. MTF LOCATION (State or Country Code.): 7 8

3. REGISTER NUMBER: 9 10 11 12 13 14 15 — [redacted]

NAME (Last, First, Middle Initial) (b)(6)-4 [redacted]

4. PAY GRADE: 16 17
5. SEX: 18

6. DATE OF BIRTH (YYYYMMDD): 19 20 21 22 23 24 25 26
7. AGE AT ADMISSION: 27 28 29
8. RACE: 30
9. ETHNIC BACKGROUND: 31
RELIGION

10. LENGTH OF SERVICE: 32 33 34
ETS
11. FMP: 35 36
12. SOCIAL SECURITY NUMBER: 37 38 39 40 41 42 43 44 45 — [redacted]

ORGANIZATION (Active Duty Only)
13. MARITAL STATUS: 46
HOUR OF ADMISSION
BRANCH / CORPS

14. FLYING STATUS: 47 48 49
15. BENEFICIARY CATEGORY: 50 51 52 — K 7 8
16. ZIP CODE OF RESIDENCE: 53 54 55 56 57 58 59 60 61

17. UNIT LOCATION (State or Country Code): 62 63
18. MOS: 64 65 66 67 68 69 70
19. TRAUMA: 71
PREV. ADMISSION — YEAR ☐ NO

20. SOURCE OF ADMISSION/ AUTHORITY FOR ADMISSION: 72
WARD
NAME/RELATIONSHIP OF EMERGENCY ADDRESSEE
ADDRESS OF EMERGENCY ADDRESSEE (Include ZIP Code)

NAME AND LOCATION OF MEDICAL TREATMENT FACILITY
TELEPHONE NUMBER OF EMERGENCY ADDRESSEE

21. TYPE OF DISPOSITION: 73 74
22. MTF TRANSFERRED TO: 75 76 77 78 79 80
23. DATE OF DISPOSITION (YYYYMMDD): 81 82 83 84 85 86 87 88 — 2 0 0 3 1 1 0 1

24. CLINIC SVC - ADMITTING: 89 90 91 92 — A B A
25. MTF TRANSFERRED FROM: 93 94 95 96 97 98
26. DATE THIS ADMISSION (YYYYMMDD): 99 100 101 102 103 104 105 106 — 2 0 0 3 1 1 0 1

27. LOCATION OF OCCURRENCE (Battle Casualty Only): 107 108
28. MTF OF INITIAL ADMISSION: 109 110 111 112 113 114
29. DATE INITIAL ADMISSION (YYYYMMDD): 115 116 117 118 119 120 121 122

FOR LOCAL USE

ADMITTING OFFICER (Signature, as required)

SIGNATURE OF ADMITTING CLERK

DA FORM 2985, MAR 2000 EDITION OF MAR 89 IS OBSOLETE USAPA V1.00

MEDCOM - 23070

Admission and Coding Information

For use of this form, see AR 40-400; the proponent agency is OTSG

Field	Value
1. Reporting MTF	(b)(6)-2 [redacted]
2. MTF Location	IZ
3. Register Number	(b)(6)-4 [redacted]
Name (Last, First, MI)	(b)(6)-4 [redacted]
4. Pay Grade	FGN
5. Sex	M
6. DoB (YYYYMMDD)	
7. Age at Admission	
8. Race	X
9. Ethnicity	9
Religion	
10. Length of Service	ETS
11. FMP	99
12. Social Security Number	(b)(6)-4 [redacted]
Organization (Active Duty Only)	
13. Marital Status	
Hour of Admission	17:24
Branch / Corps:	
14. Flying Status	N/A
15. Beneficiary Category	K78-PRISONER OF WAR/INTERNEES
16. Zip Code of Residence:	
17. Unit Location	
18. MOS	
19. Trauma	BC
Prev. Admission	NO
20. Source of Admission	Direct from ER
Ward:	ICW1
Name / Relationship of Emergency Addressee	
Address of Emergency Addressee	
Telephone Number of Emergency Addressee	
Name and Location of Medical Treatment Facility:	[redacted] No Install Provided (b)(6)-2
21. Type of Disposition	TRF-OTH
22. MTF Transferred To	
23. Date of Disposition (YYYYMMDD)	2003-11-09
24. Clinic Svc - Admitting	ABA - GENERAL SURGERY
25. MTF Transferred From	
26. Date this Admission (YYYYMMDD)	2003-11-01
27. Location of Occurrence	
28. MTF of Initial Admission	
29. Date of Initial Admission	2003-11-01

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: SOFT TISSUE WOUND

Procedure Narrative(s):

Cause of Injury Narrative:

(b)(6)-2   (b)(6)-2

Admitting Officer (Signature, as required)	Signature of Admitting Clerk
DAVIS [redacted]	[redacted]

Automated Facsimile - DA FORM 2985, MAR 2000   MEDCOM - 23071

Automated Facsimile

ATIENT TREATMENT RECORD ... VER SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr	2. Name (b)(6)-4	3. Grade FGN	Admission Remarks
[redacted] (b)(6)-4	[redacted]		

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M	42Y	Z				NO

11. FMP	12. SSN (b)(6)-4	13. Organization	14. Ward
~~99~~ 20	[redacted]		ICU3

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
NO	K78-PRISONER OF WAR/INTER	ARMY		BC

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	23:37	ABD - NEUROSURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-11-15

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-01	ARMONDA

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-01	

31. Selected Administrative Data

Marital Status: DoB: [redacted]

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW HEAD

803.20
344.40
784.3
E991.2

02.02
01.39
02.99

DX PROC · T ING / 450

80320 0202
34440 0139
7843
E9912

[redacted] (b)(6)-2

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	~~14~~ 15	~~14~~ 15

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	~~14~~ 15	~~14~~ 15

S[redacted] (b)(6)-2 MEDCOM - [redacted] (b)(6)-2

Signature of PAD or Medical Records Officer

ACLU-RDI 1675 p.32

DOD-036648

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

Iraqi O→ GSW to (L) parietal region. Initially thought expired (+) pulse transported to 28th CSH. BP responded to IV Fluid/PRBC's → GCS 7T M4 E2 S(T). Pt underwent CT w/ evidence of open depressed GSW (L) parietal region, pneumocephalus [illegible] brainstem compression.

PHYSICAL EXAMINATION

Isolated (L) Parietal Open Penetrating wound, through Skull brain exposed

pupils small reactive

unable to test EOM

motor central localization prior to [illegible] [illegible]

only on the (L), hemiplegia on (R)

no additional penetrating injuries

PROGRESS (Enter date of discharge and final diagnosis)

(1) Immediate (L) F-T Craniotomy

Decompression of Intraparenchymal Hematoma

CT of C-Spine normal,

[redacted] MD	DATE 11/1/03	IDENTIFICATION NO.	ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give: Name - last, first, middle; grade; date; hospital or medical facility) (b)(6)-2

REGISTER NO.	WARD NO.

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106

[redacted] (b)(6)-4

117.

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Neurosurg POD#1 S/P
	(L) Parietal GSW w/ Intraparenchymal hematoma
11/2/03	Pt. flex (B) LE briskly, spontaneously moving (L) UE
1431	extending (L) UE. Incis dressing intact c/d/i 24°.
	Pupil small briskly rx.
Propofol	ICP (5-9) I/O's: 141/3.8
Dilantin	JP: 110 Ventric: 85 bloody
[illegible]	121 / 24/7.5 / 127
Ancef	A/P: ICP controlled moving all but (R) arm.
INR: 1.49	(D). INR 1.49 cont monitor.
CO_2: 30.7	RR: 13
PO_2: 178	~~mode~~:
	SIMV mode
	FIO_2: 40
	Peep: 5 (b)(6)-2
11/03/03	Neurosurg POD#2
Meds cont.	Pt. noted to have spontaneous brisk (L) arm/leg movement
Fentanyl	no (R) side movement. JP removed, I/O (-75), Ventric 24
	@ height of 10 cm. Incis dressing removed, drain JP site d/c other
	wound d/c. Staples intact. INR: 1.2. Hct 25.7
	A/P: Plan attempt to wean to extubate ABG: CO_2 31.4
	(b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 6/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

SKIN AND WOUND ASSESSMENT

MEDICAL RECORD (6)(6)-2 **PROGRESS NOTES**

Admission Date: 2 Nov 03 **Diagnosis:** [redacted] GSW **HD:** 02 **POD:** 02

Skin assessment must be done initially and every 7 days.

Braden Scale Evaluation (See Braden Evaluation Table for Details)

Sensory Perception	No impairment Slightly limited Very limited Completed	4 3 (2) 1	**Mobility**	No limitations Slightly limited Very limited Completely immobile	4 3 (2) 1
Moisture	Rarely moist Occasionally moist Moist Constantly moist	4 (3) 2 1	**Nutrition**	Excellent Adequate (Eats >50%) Adequate (Rarely eats) Very poor	4 3 2 (1)
Activity	Walks frequently Walks occasionally Chairfast Bedfast	4 3 2 (1)	**Friction and Shear**	No apparent problem Potential problems Problems	3 (2) 1

Add the total score *Total Score:* 11

Above 20 Low Risk
Between 16 and 20 Medium Risk
Between 11 and 15 (High Risk)
Below 10 Very High Risk

Note: A Braden Scale Score of less than 15 indicates **HIGH RISK**-requires immediate Ulcer Prevention program.

Surgical wound (s): Yes X No__ Location: (L) PARIETAL Size: 5" Drainage: JP
Tubes: JP Pins:________ Appearance: PATENT
Dressing change: q day

Burn wound (s): Yes__ No X % BSA________ Partial________ Full________
Location:________ Size________
Appearance:________
Dressing change:________

Pressure Ulcer (s): Yes___ No X
Stage I, II, III, IV (Circle the one that applies and describe below)
Location:________ Size:________
Wound character: Pink___ Moist X Dry___ Granulation tissue___ Yellow slough___ Tunneling___
Undermining___ Odor___ Purulent discharge___ Eschar___ Exudates___
Type of dressing change: Wet-to-dry___ Comfeel dressing___ Carrasyn-V Gel___ Alginate___

Physician notified/consulted for wound debridement: Yes___ No___ Date/time MD notified N/A
CNS notified/consulted for Stage II and greater: Yes___ No___
Nutrition Referral: Yes___ No___
Physical Therapy Referral: Yes___ No___
Action taken:________ Date & Time________

REGISTER NO.	WARD NO.

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility)

PROGRESS NOTES
Medical Record
STANDARD FORM 509

PLAN OF CARE FOR SKIN BREAKDOWN AND WOUND MANAGEMENT

MEDICAL RECORD (L) Parietal **PROGRESS NOTES**

Admission Date: [redacted] Diagnosis: [redacted] HD: [redacted] POD: [redacted]

Date: 2 NOV 03 Time: 1215 RN Signature: [redacted] / 1LT / AN

Skin breakdown as evidenced by immobility, friction, shear, moisture, abrasions, surgical wound, skin tear.

Wound type: (Surgical wound (s)) Location: (L) parietal Size: 5" Drainage: JP
~~Diabetic ulcer~~ Tubes: JP Pins: ____ Appearance: CDI
Venous stasis ulcer Dressing change: ____
Other ____ Describe ____

~~Burn wound (s): % BSA ____ Partial ____ Full ____~~
~~Location: ____ Size ____~~
~~Appearance: ____~~
~~Dressing change: ____~~

~~Pressure Ulcer (s):~~
~~Stage I, II, III, IV (Circle the one that applies and describe below)~~

~~Location: ____ Size: ____~~
~~Wound character: Pink ____ Moist ____ Dry ____ Granulation tissue ____ Yellow slough ____~~
~~Tunneling ____ Undermining ____ Odor ____ Purulent discharge ____ Eschar ____ Exudates ____~~

Refer to SOP for Dressing Change Instrucitons.

Please check the appropriate dressing Change:

- ☐ Wet to Dry Dressing
- ☐ Carrasyn-V GelDressing
- ☐ Alginate Dressing
- ☐ Comfeel Dressing
- ☐ Pin Site Care
- ☐ J-Tube Care
- ☐ Colostomy Care
- ☐ Chest Tube Care
- ☐ Burn Care

NOTE: Document daily wound and dressing change on Progress Note or Nursing Note.

Select the appropriate products used:

- ☒ Sterile 4x4 gauze dressing
- ☐ Sterile 2x2 gauze dressing
- ☐ Sterile gloves
- ☒ Kerlix (super sponge)
- ☐ Gauze bandage
- ☐ Sterile Normal Saline
- ☐ Sterile Water
- ☐ 8 x 4 Sponge gauze
- ☐ Op-site
- ☐ Tegaderm clear dressing
- ☐ Alkare skin prep
- ☐ Comfeel clear
- ☐ Comfeel pressure ulcer drsg
- ☐ Carrasyn-V Gel
- ☐ Alginate
- ☐ Bacitracin
- ☐ Silvadene Cream

- ☐ Petrolatum gauze
- ☐ Hibicleanse
- ☐ Non-adhesive dressing
- ☐ Telpha Pad
- ☐ Carra-smart film
- ☐ Sterile Q-tip applicator
- ☐ Xeroform 5 x 9.
- ☐ Moisture barrier cream
- ☐ 0.125% Dakins sol
- ☐ Betadine Swab sticks
- ☐ ½ Hydrogen Peroxide & ½ Sterile Normal Saline

Select the frequency of dressing change:

- ☐ b.i.d.
- ☐ t.i.d

MD Signature and Date: ____

CNS Signature and Date: ____

Patient's Identification (For typed or written entries give: Name-last, first, middle: Grade; rank; hospital or medical facility) **Medical Record, SF 509**

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11/2/03	0330 Recv'd pt from OR S/p GSW head c̄ Ⓛ f-temporal craniotomy; Evacuation of depressed open Skull fracture. pt hooked up to monitor Vent Settings as follows V_T 700 Peep 5 FiO_2 100% BPM 12. ETT 26 @ Lip. Pt has NGT, Ventriculostomy, JP drain, and Ⓡ Femoral Cordis. D5NS c̄ 20meq KCl & Propofol infusing into Ⓡ Femoral Cordis. pt's head Wrapped c̄ Kerlex c̄ Serosangous fluid draining from Ⓛ side. Pt has Ⓡ AC IV H/L'd. FTG draining light, clear yellow urine. pt's Temp 94.4. Chief cuddler applied to pt. See DA4700 for Complete Assessment — SGT [redacted] (b)(6)-2
11/2/03	0335 #1 FFP Started VS as follows: 114/46, 78, 12, 35.7. 0340 116/59, 84, 12, 35.9. 0345 115/61, 85, 12, 36. 0400 117/63, 86, 13, 36.1 — SGT [redacted] (b)(6)-2
11/2/03	0425 #2 FFP Started VS as follows: 115/55, 85, 12, 36.6 0430 110/53, 85, 12, 36.6. 0435 127/64, 85, 12, 37.1. 0450 131/64, 81, 12, 37.1. — SGT [redacted] (b)(6)-2
11/2/03	0500 FFP #2 finished. Ø reaction noted. VSS — SGT [redacted]
11/3/03	Nursing: Pt hemodinamically stable during shift afebrile. Vent settings SIMV 11 TV 700 FiO2 40% PEEP 5 no variations during day. Wean sedation per doctor's order pt wakes easily & agitated Propofol @ 20mcg/kg/min Fentanyl 75mcg (b)(6)-4

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST, FIRST, MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	ICP <20 mmHg. Suctioned for mouth & ETT. Urine output
	adequate amounts of [illegible] NGT to LIS. 150cc
	drained during shift. [redacted] RN/AN.
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
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(b)(6)-2 whole page except last at bottom

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MEDICAL RECORD	PROGRESS NOTES
DATE	NOTES
11/3/03 1900	Recd pt from LT [redacted] @ 1815. Assessment and VS done. See DA4700 for details ——— SGT [redacted]
11/3/03	2000 pt sx'd via ETT c̄ min thick white to tan color thick mucous obtained. pt became agitated and given a total of 5cc bolus propofol. pt calmed down, HR ↓ to low 100's. ——— SGT [redacted]
11/3/03 2130	pt began to wake up again and become agitated. 2cc bolus propofol given via IVP and IV propofol ↑ to 30 mcg/hr. Fentanyl ↑ to 125 mcg/hr also. pt calm now and resting comfortably ——— SGT [redacted]
11/3/03 2200	pt's temp ↑ 103.5. 1050mg Tylenol given through NGT. Will cont to monitor ——— SGT [redacted]
11/3/03 2215	MOD notified of pt's temp. Urine and blood culture X1 ordered Both completed. Fan turned onto pt. Will cont to monitor ——— SGT [redacted]
11/3/03 2235	pt's temp ↑ 103.8. Will cont to monitor ——— SGT [redacted]
11/3/03 2300	pt's temp ↓ 103.3. Will cont to monitor ——— SGT [redacted]
11/3/03 0000	temp 101.7 ——— SGT [redacted]
11/3/03 0030	temp 101.8 ——— SGT [redacted]
11/3/03 0300	Temp ↓ 100.9. pt resting comfortably ——— SGT [redacted]
11/3/03 0500	Bed bath given and oral care done. pt tol well → (cont)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO.	WARD NO.

#[redacted]
(b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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LAST NAME	FIRST NAME	MIDDLE INITIAL	NUMBER

DATE	NOTES
	(b)(6)-2
(Cont'd)	pt resting comfortably ——— SGT [redacted]
LATE EN	TRY 11/4/03 0530 Ⓡ AC PIV leaking IVF, d/c'd and restarted
	in Ⓛ AC @ 2230. Ⓡ Radial A-Line no longer patent, d/c'd
	also. ——— SGT [redacted]
	(b)(6)-2
11/04/03	Neurosurg POD# 3
Fentanyl	Pt. showing more spontaneous Ⓛ side movement, sitting up with
Propofol	increased alertness + Ⓡ leg movement.
Zosyn	Tmax: 103.5 I/O: ⊕ 1249 ICP: 9-13
Ancef	Incis: Clean dry well-opposed
Dilantin	motor: Spontaneous movement Ⓛ UE/LE
	No movement of Ⓡ UE
	Ⓡ LE withdrawal some spontaneous flexion.
	A/P: - ICP controlled
	- Improved alertness
	- Temp w/ ↑ w/o ↑ in WBC (9.3)
	Plan: T-piece and if tolerating w/ attempt extubation.
	[redacted]
	(b)(6)-2

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

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ACLU-RDI 1675 p.40

DOD-036656

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
5 Nov 03	Pt VSS during this shift c̄ exception of Temp which the max
0615	was 102.0, given Tylenol 650mg PR X2, Temp now 101.1. Pt NGT
	D/C'd @ 2200 per [redacted] (b)(6)-2 Dr made aware of pts cont.
	aggitation 15min p̄ getting 1mg Ativan IVP, told to just observe pt.
	@ 0300 pt's ICP auto. D/C'd by pt moving around in bed, Dr
	notified. Pt weened ↓ to room air & stayed 95%-97% until this time,
	SaO2 93%, placed back on 1L O2 NC. Report given to oncoming shift.
	[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

[redacted] (b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
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USAPA V1.00

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES						
11-5-2003	Blood transfusion started 1st unit						
Time	1120	1125	1130	1140	1155	1200	1205
HR	135	130	122	128	117	123	131
BP	94/49	96/50	104/60	100/54	102/61	98/60	94/47
(T)	100.7		100.7				100.7
RR	20	20	30	28	24	26	28
SaO2	100	100	100	97	100	100	97

infusion completed w/o s/s of hemolytic reaction.

	2nd unit						
time	1215	1220	1225	1230	1240	1300	-1300 infusion completed.
HR	128	140	130	133	135	132	
BP	94/57	99/50	99/50	99/50	90/47	100/57	P.S.I 15 min tis
(T)	100.3						
RR	34	30	33	33	32	33	
SaO2	100	99	100	100		97	

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

(b)(6)-4

REGISTER NO.	WARD NO.

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	Neurosurgery Note POD#4
11/5/03	Pt. with increased activity & tracking. More
17:25	spontaneous movement.
	Tmax 101.5
	HEENT: increased swelling of Ⓛ forehead/face
	Pupils small reactive
	Eom[illegible]
	Inc: CTA
	Motor: Ⓡ arm monoplegia
	o/w briskly moves Ⓑ LE.
	likely expressive/conduction/receptive aphasia.
	[redacted] (b)(6)-2
11/6/03	Neurosurgery POD#5
0600	Pt. improved with persistent Ⓡ arm monoplegia.
	Transient appropriateness vs. confusion
D[illegible]	Tmax 100.6
[illegible]	HEENT: ↓ Edema pupils [illegible] Rx
[illegible]	incis[illegible] well intact / Flap soft
[illegible]	(Reports drainage from [illegible]).
	A/P: D/C [redacted] (b)(6)-2
	↑ Diet Clears
	D/C [redacted] (b)(6)-2
	[redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
6 Nov 03 (0630)	Assumed PT care @ 0600. PT Resting in bed; Consumed part of his morning breakfast, (1) orange juice 250 cc approx. old drainage noted on (L) side of head, Dressing Re-inforced c̄ gauzes & Tape; ~~no s/s of~~ VSS Stable, Temp 99.7, No s/s of distress [redacted] /AN
6 Nov 03 (1000)	PT c̄ Temp of 101.0, Acetaminophen 650 mg supp PR PRN given, pts Temp ↓ 99.8 @ 1100, No s/s of Distress [redacted] /AN
6 Nov 03 (1200)	PT able TO eat 100% of lunch, ~~[illegible]~~ able to point at what he wanted first, second and third in order of preference. mouth care, Bath, skin care, foley care and ROM exercises performed around 1215; pt was able to brush his teeth, and wash the part of his body c̄ minimum assistance using (L) Arm unable TO move (R) arm s̄ support, unable TO wash his back; (L) side stronger than (R) side, pt able to move Bilateral lower extremities & (L) arm more than (R) arm. [redacted] 1LT/AN
6 Nov 03 (1305)	Dressing TO (L) side of head changed c̄ gauzes Dry ~~[illegible]~~ Intact, staples intact, ∅ active bleeding noted, no s/s of infection. Pt tolerated procedure well [illegible] 1LT/AN
6 Nov 03 (1640)	PT c̄ Temp of 101.1, Acetaminophen 650 mg supp PR PRN given, Temp ↓ 98.6 [illegible] 1LT/AN
6 Nov 03 (1830)	[redacted] ~~on~~ ~~the~~ OK'd THE use of Flexora / Cortis line, PT c̄ weakness & Edema on (R) Arm, (L) Arm HE uses it

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

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DATE	NOTES
	TO support & move Himself, only GOOD place for a line, would be in
	(R) leg which He has His cordis placed line still patent
	& good for use. PT'S condition improving greatly, able
	TO follow commands, fed himself c̄ spoon, understands
	Simple commands - report given TO SPC [illegible], PT [illegible]
	in [illegible] ∅ S/S of distress or complaint, also PT
	eat 100% of Dinner ——— [redacted] / [illegible]
6NOV03 1900	assumed PT care @ 1900. Received report from LT [redacted].
	assessment in Flow chart. PT ate 100% of dinner (clears diet) [illegible]
	now resting on left side. will continue to monitor ——— SPC [redacted]
2100	VSS PT rolling from side to side during sleep. is in
	NAD will continue to monitor ——— SPC [redacted]
2200	stopped IVFL for [illegible] med run. PT still sleeping
	comfortably w/ temp at 100.1 has not risen in last 2 hrs — [redacted]
2330	VSS temp steady @ 100.1 PT sleeping meds are running
	will continue to monitor ——— SPC [redacted]
0145	VSS PT RESTING. Temp remains slightly elevated. UOP
	still above 100 cc/hr. PT is in NAD will continue to
	monitor temp ——— SPC [redacted]
0440	LABS drawn, AM Done. [illegible] 0600 med hanging. PT still
	sleeping comfortably. will continue to monitor ——— SPC [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
	Neurosurg Note
11/7/03	Pt. awake alert appropriate. Participating in
09:18	Self care, brushing teeth washing self.
	AFEBS VSS
	Incis - Clean dry well-opposed
	motor: Briskly moving (L) arm. (B) LE
	(R) arm monoplegia
	A/P: Plan to transfer to ICW
	D/c IV's advance diet
	[redacted] (b)(6)-2
7 Nov 03	Nutrition Note
1010	Pt doing well on CLD today + yesterday. Ø GI complaints.
	Recommend advancing to FLD + to Reg as tol. (b)(6)-2
	[redacted] CPT, SP
7 Nov 03	Pt alert and responsive to tactile and
1010.	verbal stimuli. Pt able to move (L) hand and both
	feet. (R) hand is limp. Pt able to practice own PROM
	with use of (L) arm. Also to sit-up in bed [redacted] (b)(6)-2

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[redacted] (b)(6)-4		

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	tolerated his early AM meds IVPBs and IVF. Pt
	well hydrated. Urine output adequate. Pt has
	slightly elevated temp of 100.9°F, temp decreased
	to 100.5. Staples in head wound/incision intact -
	25 staples total. Pt gown D/C, foley D/C, removed line D/C.
	Pt prep for ICW I. Tolerating clear liquid 150cc well
	(b)(6)-2
4/1/07/03	1100/ Pt report given 8 LO
	(b)(6)-2

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DOD-036663

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
08NOV03	(cont) diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ S/Sx complications. Will continue to monitor.
9NOV03 @ 0030	Assumed care of pt @ 1800. VSS. alert, speaking garbled noises, but follows commands & seems to understand English. PERRLA, (R) side facial droop noted c̄ smiling, RUE weakness noted, but marked improvement in last 24° c̄ pt now able to move finge[rs]. BLE equal, steady gait noted c̄ ambulation, but pt drags (R) foot slightly. LS CTA; ⊕ BS, tol reg diet well; voids to urinal s̄ difficulty. Pt ↑ AMB x 20-25 min s̄ difficulty. 2pt restraints in s̄ S/Sx of skin or circulation compromise. Plan: monitor neuros, monitor VS, enc po intake. Ace bandage provided for pt for hand exercises.
09 NOV 03 1015	Assumed care @ 0600. VSS. Alert & O able to make needs known c̄ interpretor asst. RUE weakness. Unable to arm s̄ asst. Can move fingers slowly. Purposeful movement of LUE & BLE. Ambulates slowly c̄ minimal asst. to bathroom for AM care & in hall s̄ asst. Staples C/D/I to (L) side of head. PERRL. Will continue monitoring neuro status; encouraging hand exercise c̄ Kerlix pack. 2 pt restraint s̄ compromise to skin or circulation.
09 NOV 03 1700	Ambulating in halls s̄ difficulty. Drags (R) foot when ambulating. Will continue to monitor.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11/8/03	Neurosurgery
08:39	Pt. awake, alert appropriate [illegible] Ⓡ
	monoplegia + receptive aphasia
	AF[illegible] VSS
	incision clean dry well approxed
	[illegible] OOB ambulate w/ assistance
	[redacted] (b)(6)-2
ERROR WRONG PT ~~08NOV03~~	~~(1205) Assumed care of pt from 100³ via gurney in~~
	~~stable cond. Pt alert, speaking Arabic. VSS. ∅ c/o~~
	~~pain. Drsg to RLE CDI. Drsg to RLE c̄ small amount~~
	~~serosang drainage @ the knee. Drsg to LLE CDI.~~ [redacted]
08NOV03	(1210) Assumed care of pt @ 0000. Pt alert. Able to
	follow verbal commands. VSS. ∅ c/o pain. Ⓛ sided
	facial drooping noted. Pt cont. to be unable to
	control Ⓡ hand/forearm, has min. control over Ⓡ
	shoulder. Rom done c̄ pt. Amb in hallway c̄ small
	episode of dizziness @ start of amb. Staples to
	Ⓛ side of head CDI s̄ s/sx infection. Tol. reg

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#[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
8/10/03	(CONT): (R) sided facial weakness noted, especially to mouth, difficulties drinking H2O noted. RUE weakness significant, dangles arm, able to use shoulder & upper arm strength, but cannot grasp or maintain control of (R) hand. BLE equal in strength, but pt c̄ unsteady gait when ambulating. Incision to (L) temporal lobe OTA, staples intact, ø drainage noted. Pt ↑ to BR c̄ assistance, tol well. LS CTA, ⊕BS, voids s̄ difficulty to urinal. Plan: monitor neuros, Dilantin as ordered. 2 pt restraints on s̄ s/sx skin/circulation compromise). Will monitor. [redacted] (b)(6)-2

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USAPA V

ACLU-RDI 1675 p.50

DOD-036666

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7NOV Ø3 1210	Pt admitted via gurney from ICU#2. Pt awake, making gestures c̄ hand, trying to communicate c̄ roommate. Pupils small & reactive, old dry blood noted to Ⓡ nostril. Pt c/o not being able to taste his food. Pt is also unable to speak @ this time. Ⓡ sided weakness noted, unable to move Ⓡ arm but can wiggle Ⓡ toes (*at the same time as left toes). ⊕1 edema noted to Ⓡ hand & foot. Ⓛ hand & foot c̄ ⊕2 pulses, Ⓡ hand & foot c̄ ⊕1 pulses. 25 staples noted to Ⓛ temporal ~~lobe~~ side of head. Well approximated c̄ Ø drainage noted. Foley d/c'd in ICU. Pt due to void by 2000 hrs. Pt able to ambulate c̄ assistance, could not use crutches due to Ⓡ sided weakness. had soft-brn formed BM x 1. Ø IV access. Ø skin breakdown. 2 pt restraints on s̄ compromise to skin/circulation. Will monitor [redacted] (b)(6)-2
8NOV03 @0205	Assumed care of pt @1800. VSS, no c/o pain. alert, speaks unclear arabic but understands English commands. PERRLA, c/o unable to taste food. (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER
				[redacted]

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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*	REGISTER NO.	WARD NO.
		ICW# 1

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E# [redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
9 NOV. 03 2030	Pt A+Ox3, VSS, LS CTA (B), (+) BSx4, staples to (L) side of head CDI, Ø drainage noted, weakness to RUE, able to move extremity slowly, voiding CYU to urinal, tol most of diet, encouraged exercising RUE, will continue to monitor, 2 pt restraint, Ø complications [redacted] (b)(6)-2
	Neurosurgery
11/10/03 0922	Pt c/o (L) radicular leg pain. Has progressive increase in strength & activity in (R) arm & hand. Previously (R) monoplegic now has antigravity strength.
	AF&B
	Motor ambulate Raises (R) arm no resistance but able to move individual finger & thumb
	A/P: (1) ↑ Activity
	(2) OOB & chair walking (Viox for radiculopathy)
	(3). D/C Dilantin.
	[redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME — LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

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[redacted] (b)(6)-4

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10NOV03	(1010) Assumed care @ 0800. Pt alert, speaking Arabic.
	VSS. Pt c/o back pain radiating down legs. MD
	notified - pt started on Vioxx. Pt given IS c̄ instruction
	Demonstrated correct use of IS. ROM c̄ RUE improving
	ROM exercises done. Staples to Ⓛ side of head CDI
	Pt tol. reg diet well. Voiding s̄ difficulty. 2 point
	restraints in place s̄ s/sx complications. Will cont.
	to monitor. ——— [redacted]
	(1630) Pt OOB to amb in hallway. ROM exercises
	being done c̄ Ⓡ arm while amb. Tol. well. ∅
	c/o pain. Monitoring. ——— [redacted]
11NOV03	VSS. Pt c/o scrotal pain. V/O for Tylenol 650mg.
	Pt amb on floor. Tolerated well. Sat up in chair.
	Pt request to sleep in chair 2° ↓ scrotal pain.
	Pt sleeping in room in chair. Appears to be comfortable
	Pt has sutures to Ⓛ side of head. Sutures well-
	approximated c̄ ⊖ S/Sx of infections. Pt has ↓
	strength in Ⓡ UE compared to Ⓛ UE. Pt needs to
	assist Ⓡ side in mvmt. ——— [redacted]
11NOV03	(0830) Assumed care @ 0800. Pt alert, speaking few
	words in Arabic. VSS. ∅ c/o pain. Pt OOB to amb
	in hallway while doing ROM exercises c̄ Ⓡ arm.
	ROM cont. to improve. Pt able to lift Ⓡ arm
	above head and move fingers. ↑ in chair @ this
	time. Staples to Ⓛ side of head CDI s̄ s/sx
	infection. Tol. reg diet well. Voiding s̄ difficulty.
	2 point restraints in place while in bed. ∅ [redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
13NOV03@1500	Assumed care of pt. @ 0600. V.S.S., A&O×3, Ø c/o pain. Incision to Ⓛ side of head, edges well approximated, Ø drainage, staples removed yesterday. Pt. ambulates well in hallway, steady gait. Slight weakness noted to Ⓡ UE. Pt. performed Ⓡ UE excercises. Pt. demonstrates correct use of I.S. Lungs clear bilaterally. Urinal at bedside, clear dark yellow urine. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. [redacted] (b)(6)-2
13NOV03 2000	VSS alert & oriented. Denies pain, discomfort N/V @ this time. Incision to Ⓛ side of head edges well approximated. Up ad lib c̄ steady gait. Consumed 80% of dinner. Perform Ⓡ arm exercise properly. Wanting to know when he'll leave to Return to camp. 2+ restraints applied without compromising circulation or skin integrity. Will continue care as planned. [redacted] (b)(6)-2
14NOV03	(1210) Assumed care @ 0700. Pt alert, not speaking words clearly. Able to verbalize needs c̄ gestures. VSS Ø c/o pain. Amb in hallway s̄ difficulty ↑ to chair. Performs arm ROM exercises c̄ Ⓡ arm. Incision to scalp CDI. Tol. reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will continue to monitor. [redacted] (b)(6)-2

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
11NOV03 (0930)	(cont) complications. Will cont. to monitor. [redacted] (b)(6)-2
12NOV03 @ 0045	VSS. Pt ⊖ c/o pain. ~~staples~~ Staples on Ⓛ side head well approximated, ⊖ S/Sx of infection. Pt still unable to verbalize wants + needs. Uses hand motions ~~to~~ + gestures to make needs known. Ⓡ weakness. Pt uses Ⓛ hand to move Ⓡ hand. Pt able to amb c̄ steady gait. Urinates s̄ difficulty in urinal. Tol PO diet. Will continue to monitor. [redacted] (b)(6)-2
12NOV03	(1125) Assumed care @ 0000. Pt alert, not speaking this am. VSS. ⊖ c/o pain. Pt OOB to amb in hallway s̄ difficulty. ROM to Ⓡ arm done by pt. ROM cont. to improve. Staples to scalp dc'd by MD. incision CDI. Tol reg diet well. Voiding s̄ difficulty. 2 point restraints in place s̄ S/Sx complications. Will cont. to monitor [redacted] (b)(6)-2
12NOV.03 1930	Pt resting in bed, A+Ox3, VSS, encouraged Ⓡ arm exercising, Ⓛ side of head incision CDI, consumed 90% of diet, voiding s̄ difficulties to urinal, 2 point restraint, ⊘ complications, peripheral pulses +2, equal Ⓑ, [redacted]

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11/14/03	Neurosurgery Narrative Summary
07:53	Pt. is a twenty-six yo EPW Iraqi ♂ who arrived with a GSW to the
	head (L) frontotemporal region. Pt. arrived 11/1/03 with an initial GCS 6T;
	4 motor, 1 verbal, 1 eye opening, pupils sluggish (c) 2mm in size. Entry wound
	on the (L) superior temporal line no exit wound; noted to be hemiplegic on
	the (R) and localizing (L). CT demonstrated an open depressed skull
	fracture with intraparenchymal hematoma, subarachnoid, Sylvian
	fissure blood. He underwent emergent (L) frontotemporal craniectomy (bone flap left out due to ↑ICP).
meds:	~~craniotomy~~, evacuation of hematoma, bone fragments &
Dilantin	placement of a ventricular/ICP monitor in the subdural space.
100mg q 8°	He tolerated the procedure well, the JP drain was removed
	on POD#2 was subsequently extubated POD#4. He was
	subsequently transferred to ICW step-down. Post-operatively he
	has significantly regain function of his (R) arm/ambulating independently,
	he has a partial aphasia (expressive less so than receptive).
	which is improving.
	D/C Dx: (1). (L) Penetrating Brain Injury
	(2). Residual Aphasia 2° to PBI to (L) frontotemporal Region.
	(3). Mild (R) proximal UE extremity weakness (improving).
	Rec: (1). Continue Dilantin × 3 months. [redacted]

(b)(6)-2

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[redacted] (b)(6)-4

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
14NOV03 @2245	assumed care of pt @1800. VSS. 70-90. alert, understands English, slurred speech noted. PERRLA, slight Ⓡ sided facial weakness noted. RUE strength < LUE, but improving; able to control RUE ē Ⓡ hand. (performing exercises independently). Pt ↑AMB ē difficulty. Tol reg diet (85% of meals), voids ē difficulty. Plan: D/C orders noted, cont enc independence & enc exercises. Addendum: incision to Ⓛ occipital/temporal lobe OTA, CDI. 2pt restraints on ē s/sx of skin/circulation compromise. Will cont. to monitor. [redacted] (b)(6)-2
15NOV03	(1205) Pt stable for d/c to camp. Ambulatory - escorted by MPs. [redacted] (b)(6)-2

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

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MEDICAL RECORD	CHRONOLOGICAL RECORD OF MEDICAL CARE
DATE	**SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION** *(Sign each entry)*
	Brief neurosurg OP note
11/1/03	Pre-op Dx: (L) Parietal GSW Head
0249	Post-op Dx: (L) GSW parietal, Parietal Hematoma, Pneumoceph
	Proced: (L) Parietal Temp. Front Craniotomy
	Evacuation of Hematoma, Bone Fragments
	Placement of Subdural Fiberoptic Ventricular
	Catheter, Subgaleal Drain
	Left Bone flap out.
	Surgeon: [redacted] (b)(6)-2
	EBL: 500cc U/O: 1100 Fluids: 4L Crystalloid 300 LR 3700 NS
	Comp: Ø 2u FFP
	Drains: JP Subgaleal / Subdural ventricular catheter fiberoptic
	[redacted]
	(b)(6)-2

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT

SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*	REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
Prescribed by GSA/ICMR
FIRMR (41 CFR) 201-9.202-1

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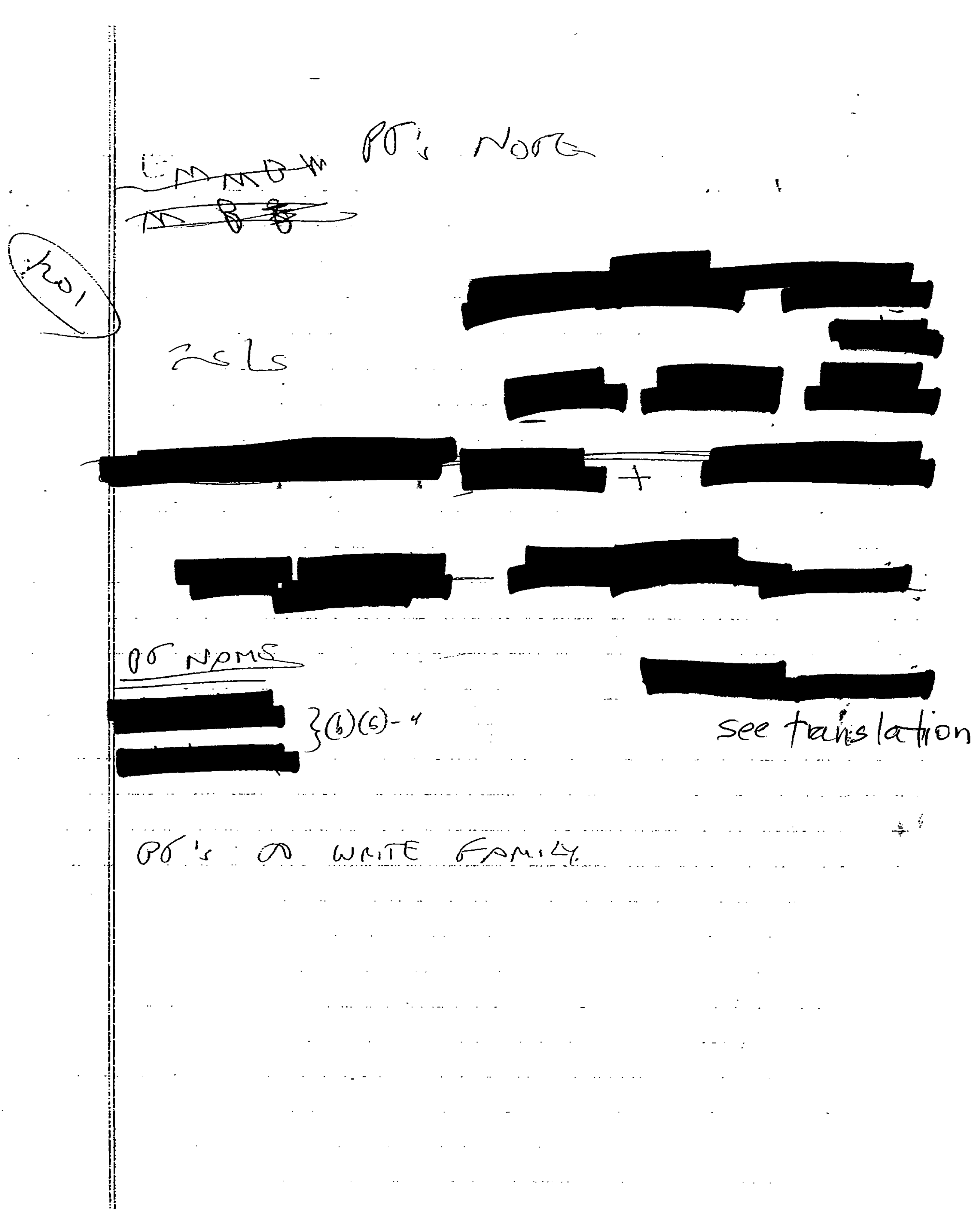
DOD-036674



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Translation Bates page Medcom 23099:

[redacted]

(rest of translation does not make sense in Arabic)

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11-2-03	0625		Pt received from outgoing shift, MOB ↑, midline (R) ventric @ 6cm for external drainage system, bright red blood sputum; ICP 5; head is wrapped in gauze; ½ dollar size blood drainage (posterior scalp); Ø resp. to pain other than PMR; Ø movement; Ø eye opening; PERRL @ 2mm (R) sunken than (L); (R) # 7.5 ETT 26 to lip, FiO2 40%, TV 700, RR 12, PEEP 5, PK 18-22; CO2 on last ABG 35.2; CTA (B) [illegible]; [illegible] NSR although [illegible] ST [illegible] (80s), [illegible] 140s [illegible], [illegible] 80s; S1, S2; +3 pulses x 4 ext (-) edema [illegible]; (+) BS x 4 [illegible]; NGT [illegible]; [illegible] clear, yellow urine (3cc 710) [illegible]; large gauze [illegible]; [illegible] (R) [illegible]; (R) [illegible] 125; [illegible] ICP [illegible]; CO2 (32-35)
	900		[illegible]
			— [redacted] (b)(6)-2
	0943		ABG results for 0500 received; CO2 38; will ↑ RR up 2 to achieve CO2 desired range of 30-35.
			— [redacted] (b)(6)-2
			[redacted] (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] (b)(6)-4

REGISTER NO. | WARD NO.

NURSING NOTES
Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23100

(b)(6)-2

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
[illegible]		1800	[illegible] re: spont movement [illegible] patient's left side UE flex, LE flexion; left side only; Ø [illegible] [illegible]; Ø purposeful movement; spont flexion [illegible] ICP [illegible] 12, HR [illegible]
			[redacted] [illegible]/AN
3 Nov 03	0300		[redacted] into check on pt. MD notified of A line discrepancies & inability to draw blood. MD OK c NBP readings. Notified of ↑ temps Tylenol ordered. Ventriculostomy repositioned @ 10 cm above EAC. Fentanyl drip ordered for pain. [redacted]
3 Nov 03	0400		Pt's urine now c greenish discoloration. Pt receiving propofol. Green urine known side effect. UOP adequate. Will continue to monitor. [redacted] (P) [illegible]/AN

510-112

NSN 7540-00-634-4123

MEDICAL RECORD

NURSING NOTES
(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11-4-2003	0650		Pt recieved from off going shift. HOB ↑ pt midline. (R) Ventric Ø 10cm above EAC; minimal draining; red → clear in color; ICP monitor from 10-13; Eyes PERRL 2mm ⊝ brisk ⊝ sluggish (in saturation); Attempts to open eyes to painful stimuli; (↑ HR noted); Ø retraction; spont. movement to (L) side - raises arm; wiggles leg; wiggles (R) leg; Ø movement noted to (R) UE (R) #7½ ETT 26cm @ lip; SIMV; ~~600~~ TV; 40%; PEEP 5; ~~CTA (B)~~ ↓ in bases; coarse (B); sats 100% on above settings; ⊝ cyanosis noted; minimal clear-white secretions on oral suctioning [CV] ST 100s-120 febrile; NIBP 100s/60s; +3 pulses; ~~sent edema~~ Ø edema noted [GI/GU] hypoactive BS noted; NPO; NGT to LIWS; foley to gravity u/o 6 (see I/O) (Skin) large lower wound with gauze wrapping (lines) (R) fem. cordis; (L) PIV; foley, NGT; OSHs w/ 20cc @ LWS; fent @ 150mcg/hr, prop. @ 9cc/hr; (Plan) ↓ in sedation, attempt to extubate ~~...~~
			[redacted] (b)(6)-2
	0910		D/C'd out ventric drainage system; CSF seen flowing - will record on I/O; CXR taken —
			[redacted] (b)(6)-2
			[redacted] (b)(6)-2

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted] (b)(6)-4

REGISTER NO.

WARD NO. ICU

NURSING NOTES
Medical Record

MEDCOM - 23102

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202

(b)(6)-2 whole page

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
11/4/03	1100		T [illegible] started will get ABG in 30 min; Pulled out ETT 2 cm 25 cm @ lip — [redacted]
	1200		Extubated with RT/Dr [illegible] assisting; SaO2 100% on 5FM (3L); Ø follow commands; current RR 15-23; SaO2 100%; HR 140; BP 110-120/60; Dr [illegible] present @ extubation & exam; Ø sedation/pain medication [illegible] received. — [redacted]
03 NOV 2003	1643		Pt. ↑ in HR/RR; pt becoming anxious; ↑'s [illegible] movement; HR 150s; RR 30s-40s; SaO2 [illegible] 92%; ABG obtained on 40% FM = PO2 [illegible]; Interpreter in area to talk with patient

*U.S. Government Printing Office: 1995 - 404-763/20065

STANDARD FORM 510 (REV. 7-91) BACK

MEDCOM - 23103

ACLU-RDI 1675 p.64

DOD-036680

(b)(6)-2 whole page

NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
5 Nov 03	1200		Notified neurosurgeon re: ↑ in swelling to (L) side of face. Will continue to elevate head c̄ suction through nasal trumpet.
			[redacted] [illegible]
			[redacted]
6 Nov 03	0630		Pt stable throughout this shift, given 650mg Tylenol PR for 101.4 Temp ↓ 100.4. Pt had 2 watery stools on this shift. Pt restless throughout shift, interpretor called up to try to talk to pt. Pt unable to speak but able to write, interpretor stated most of it was "gibberish." Report given to oncoming shift & pt in stable condition.
			[redacted]

*U.S. Government Printing Office: 1995 - 404-763/20065

MEDCOM - 23104

STANDARD FORM 510 (REV. 7-91) B

ACLU-RDI 1675 p.65

DOD-036681

(b)(6)-2 except for very bottom

510-112 NSN 7540-00-634-4123

MEDICAL RECORD — NURSING NOTES

(Sign all notes)

DATE	HOUR A.M.	HOUR P.M.	OBSERVATIONS Include medication and treatment when indicated
			Pt recieved from off going shift; HOB ↑;
			Activity ē medication for [illegible] as order.
			Assessment as follows: [N] Pt tracks staff as they walk.
			Spont movement noted x3 extremity (L UE, R LE); paral 3m
			~~Pt appears to be~~ ↑ in activity level from
			yesterday & last night. Resting comfortably; [R] Coarse
			BS (B) (most notable L>R); sats 95% 2L n [illegible];
			[CV] ST 110s-120s; 90s/40s - 110s/40 NIBP; +3 pulses
			x4 extremity; AFebrile; [GI] (GT) [illegible], hypo
			active bowel sounds (GU) foley to gravity with clear
			yellow urine; (SKIN) posterior scalp has former medic
			site - C/D/I; [LINES] (R) fem cardis - NS with 20K @ 125;
			(L) DW: [illegible] monitor; control movement / [illegible]; ?
			transfuse for ↓ H/H (6.2/19.9) 14/[illegible]
	1030		Nasally tracheal suction removed large amount
			of clear-yellow secretions. Repositioned [illegible].
	1300		2 units PRBC finished ē s/s of reaction.
			Pt repositioned x 2; Nasal suctioned x3
			for clear/yellow secretions. [illegible]

(Continue on reverse side)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; rank; rate; hospital or medical facility)

REGISTER NO.

WARD NO. [illegible]

(b)(6)-4

NURSING NOTES

Medical Record

STANDARD FORM 510 (REV. 7-91)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23105

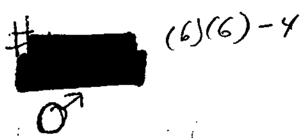
MEDICAL RECORD	**PREOPERATIVE/POSTOPERATIVE NURSING DOCUMENT** For use of this form, see AR 40-66; the proponent agency is The Office of the Surgeon General.
1. AGE: HEIGHT: WEIGHT:	2. KNOWN ALLERGIC SENSITIVITIES (e.g., Iodine, Tape, Medication): 3. PREVIOUS SURGERY [ ] NO [ ] YES (type):

4. PROPOSED SURGICAL PROCEDURE:

5. ADDITIONAL INFORMATION: Last PO: Medical Hx: Implants: Medications:
Jewelry removed: yes/no Family waiting: yes/no
Watch

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
A. PSYCHOSOCIAL X Potential for anxiety related to traumatic injury; language barrier; family separation; surgical environment	Pt. verbalizes any specific anxiety. Pt. exhibits relaxed body posture.	Allow pt. to verbalize freely. Explain OR environment and answer questions regarding surgery. Offer comfort measures, (e.g., warm blanket, touch) Explain all nursing procedures before they are done. Remain with pt. whenever possible. Maintain family interface.
B. AERATION X Potential for respiratory dysfunction due to sedation; positioning; injury	PT. will be able to breathe without difficulty during immediate intra-operative phase.	Offer to elevate head of litter or offer pillow. Observe pt. while awaiting surgery for signs of distress Assist anesthesia during intubation and extubation
C. INTEGUMENT X Potential impairment of skin integuity due to bovie pad; position; fluid shift	PT. will not exhibit signs of impairment of skin integrity (e.g., reddened areas.	Utilize pressure preventing devices on OR table and accessories. Check for proper positioning and support to maintain good body alignment. Pad pressure points. Place ESU ground pad on non compromised skin surface area. Keep prep fluids from pooling.

9. PATIENT'S IDENTIFICATION (For typed or written entries give: Name- last, first, middle; grade; date; hospital or medical facility)


(b)(6)-4

ACLU-RDI 1675 p.67
DOD-036683

(b)(6)-2 whole page

6. PATIENT PROBLEMS AND NEEDS	7. PATIENT GOALS AND EXPECTED OUTCOMES	8. OR NURSING INTERVENTIONS
D. CIRCULATION X Potential for inadequate tissue perfusion due to anesthesia; traumatic injury; position; shock; previous surgery	ϕ Pt. will exhibit signs of adequate tissue perfusion (e.g., color, warmth, pedal pulse).	o Check for support stockings or ace wraps. If none, check with doctors. ϕ Check that safety straps are correctly applied. ϕ Offer pillow for under knees. o Place and take down legs from stirrups with slow bilateral motion. ϕ Check that rings have been removed.
E. NEUROMUSCULAR CONTROL E.1. X Potential impairment of mobility due to sedation; pain; injury E.2. X Potential discomfort due to injury; pain	ϕ Pt. will be transferred to OR table without difficulty. ϕ Pt. will not experience unnecessary physical discomfort.	ϕ Have sufficient people available for transfer. ϕ Insure proper body alignment. ϕ Allow patient to lie in position of comfort while waiting for surgery. ϕ Offer support (i.e., pillows, bathtowels, etc.) for positioning.
F. NEUROMUSCULAR CONTROL F.1. X Disminished visual perception due to being injury; sedation; F.2. X Potential for decreased communictaion due to language barrier; sedation F.3. Potential injury due to dentures.	ϕ Pt. will be made aware of surroundings prior to anesthesia induction. ϕ Pt. will be transferred safely to OR table. ϕ Pt. will be able to understand instructions. ϕ Minimize danger of injury during intraop period.	ϕ Introduce self. Keep pt. informed as to where he/she is and what is happening. ϕ Inform pt. in which direction to move and assist if necessary. ϕ Speak clearly and slowly. ϕ Address pt. from either side. ϕ Validate pt.'s understanding of verbal communications. o Verify removal of dentures.
G. OTHER PATIENT PROBLEMS NEEDS. Or continuation of above problems/needs.	OTHER PATIENT GOALS AND EXPECTED OUTCOMES. Or continuation of above goals and outcomes.	OTHER NURSING INTERVENTIONS. Or continuation of above interventions.

10. OR NURSING INTERVENTIONS COMPLETED/ADDITIONAL INTEROPERATIVE INTERVENTIONS NOTED.

[redacted] CPT/AN 2 Oct 03 DATE

11. POSTOPERATIVE EVALUATION:

Bovie: D&I
Dsg: C/D
LOC: Intubated
Resp:

12. PREOPERTIVE EVALUATION PREPARED BY (Signature and Title)

[redacted] CPT/AN

DATE: 2 Nov 03 TIME: 0006

13. ~~PRE~~ Post OPERTIVE EVALUATION PREPARED BY (Signature and Title)

[redacted] CPT/AN

DATE: 2 Nov 03 TIME: 0223

REVERSE OF DA FORM 5179, JUN 91

USAPA V1.01

MEDCOM - 23107

(b)(6)-2 except for very bottom

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**

For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA litter BY anesthesia
2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY
3. DATE 2 Nov 03 TIME PATIENT ARRIVED IN SUITE 0007
4. PATIENT IN ROOM TIME 0007 NUMBER

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☒ OTHER *(Specify)* intubated

COMMENTS: Allergies:

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	CPT [redacted] CPT [redacted]	RELIEF CIRCULATOR	

7. POSITION AND POSITIONAL AIDS *(Specify)*

☒ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS: Head in Mayfield headrest, Ⓛ arm tucked at side

8. SKIN PREPARATION

HAIR REMOVAL ☒ YES ☐ NO
DONE BY: ☐ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☒ RAZOR ☐ CLIP
COMMENTS: No nicks

PREP SOLUTION *(Specify)* Betadine scrub/soln
SITE: Lt. [redacted] BY WHOM: [redacted]
SITE: BY WHOM:
COMMENTS: No pooling of fluids

9. LOCATION OF EXTERNAL DEVICES

X 90°

LEGEND X Ground Pad -- Safety Strap === Tourniquet

C = Correct I = Incorrect

10. COUNTS			Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
						Initial [redacted]	
Sponge	☒ Yes	☐ No	/		C	[redacted]	[redacted]
Needle Sharp	☒ Yes	☐ No	/				
Instrument	☐ Yes	☒ No	/				
Other	☒ Yes	☐ No	/				

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

[redacted]

(b)(6)-4

12. ELECTROSURGERY DEVICE(S) (ESU) ☒ YES ☐ NO

☒ ESU NO: Force 40 #1 50/50
GROUND PAD: BRAND Valleylab REM
LOT NO: 68245

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☒ BIPOLAR NO: Force 40 #1

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(b)(6)-2 whole page

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

Ventricular ICP Monitor
Lot #EV 235

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☒ NO ☐

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY
1% Xylocaine w/EPI 1:100,000	10cc	intraop	inj		[redacted]
Thrombin 20,000u		intraop	topical		↓
Surgicel		intraop	topical		↓
Bicol #AV226	X	intraop	topical		↓

WOUND IRRIGATION ☒ YES ☐ NO, TYPE(S):

0.9% NS

OTHER ORDERS	TIME	CARRIED OUT BY
None		

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE

YES ☐ NO ☒

16. LABORATORY SPECIMENS

	NAME	NAME
SPECIMEN (S) YES ☐ NO ☒		
FROZEN SECTION (FS) YES ☐ NO ☒		
CULTURE (C) YES ☐ NO ☒		
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

	1.	2.	3.
TYPE/SIZE	JP Drain 10mm		
SITE	Lt head		

18. DRESSING/IMMOBILIZATION *(Specify)*

4x4
Kerlix

19. ADDITIONAL INFORMATION

WC

Surgeons: [redacted] Anesthesia: [redacted] CRNA Anesthesia Type: General

Bovie Pad site intact pre-op ✓ ; post-op ____ Bovie Settings: Coag/Cut
Tourniquet Site intact pre-op ____: post-op ____
Tourniquet Time: Up ____ Down ____

Watch w/pt.

20. OPERATION(S) PERFORMED

1. Evacuation of intraparenchemal hematoma

21. PATIENT TRANSFERRED TO: ICU 3 TIME: 0213 METHOD: Litter

22. REGISTERED NURSE SIGNATURE

[redacted] CPT/AN / [redacted] CPMN

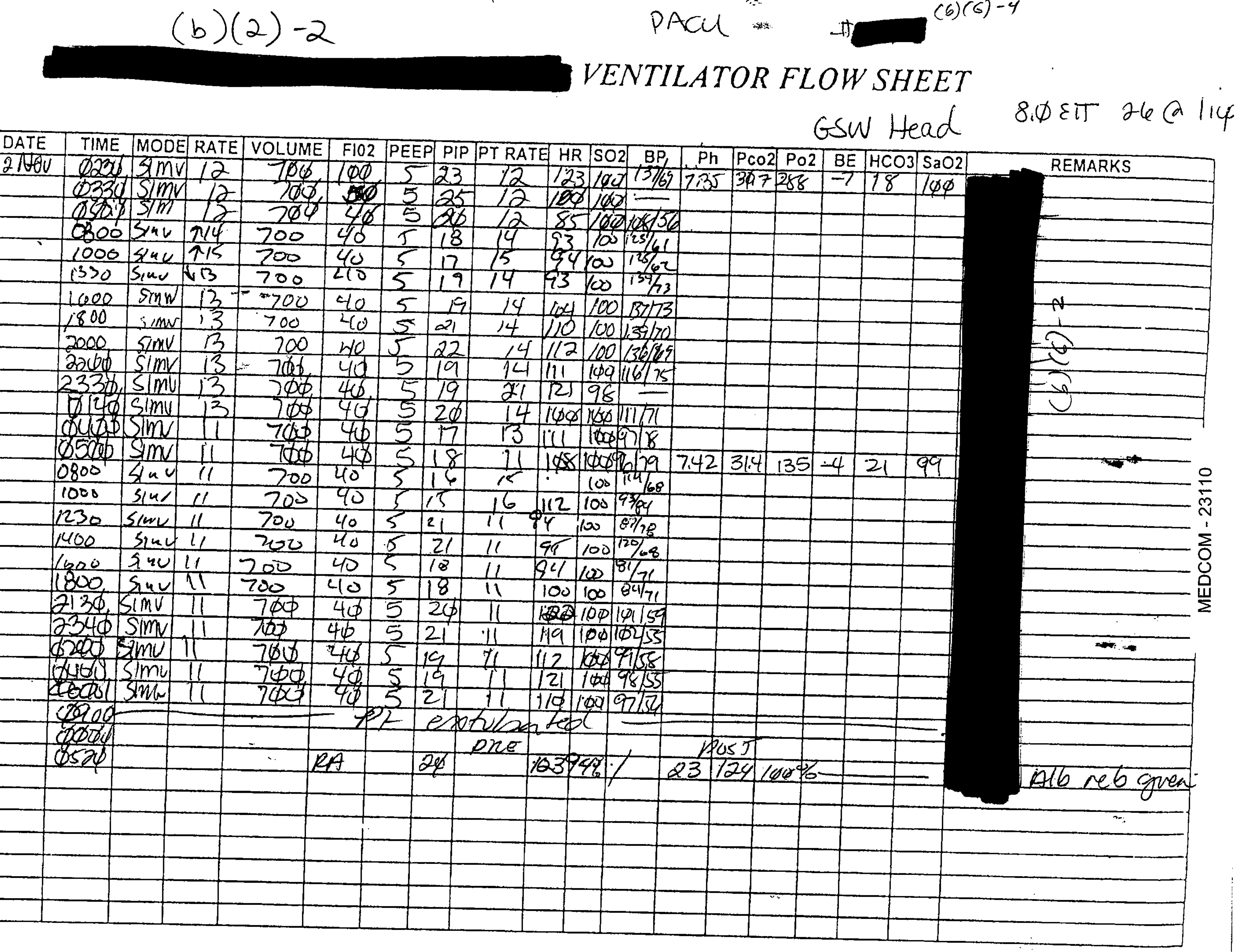
REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 23109

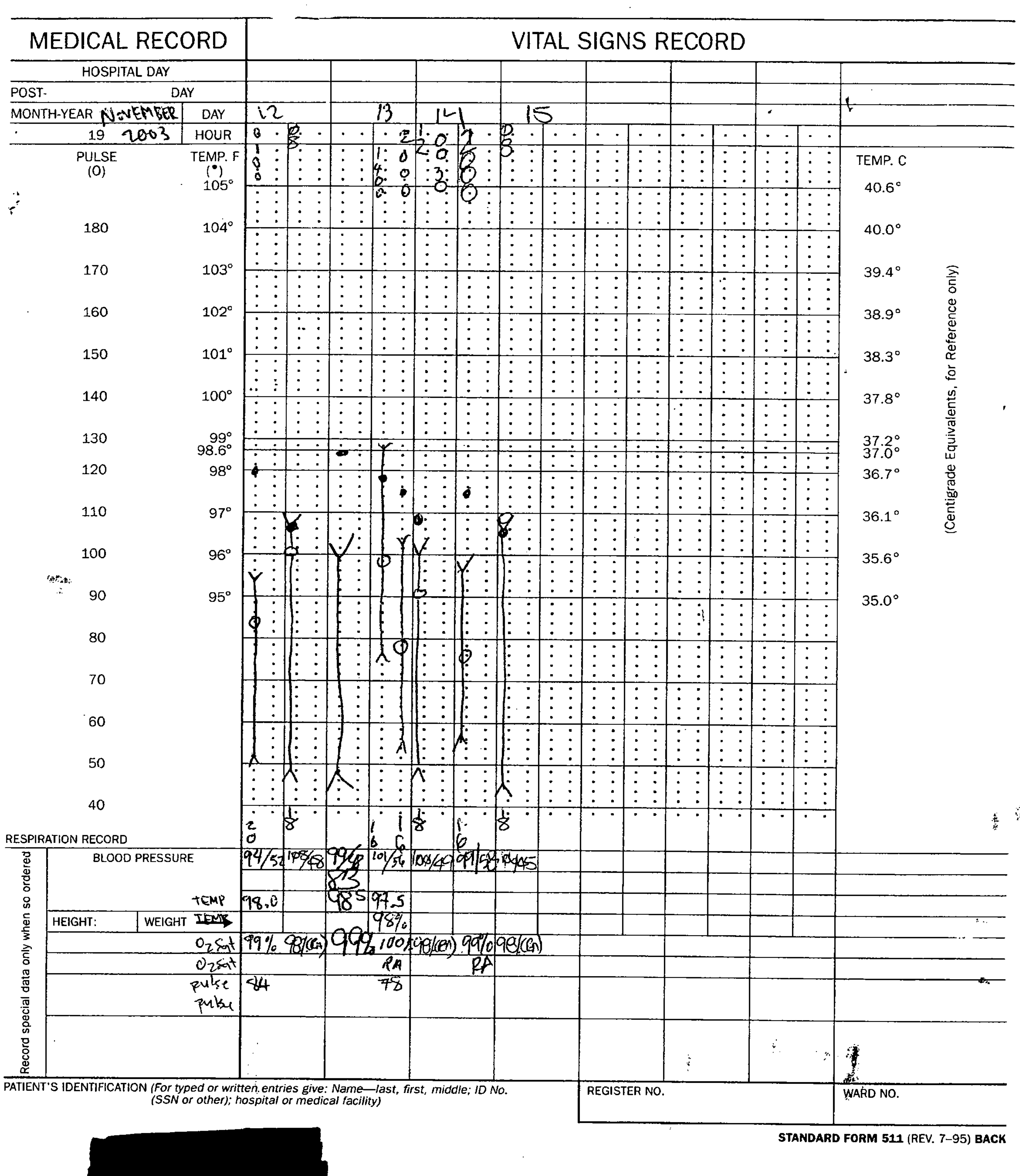
(b)(2)-2 PACU # (b)(6)-4

VENTILATOR FLOW SHEET

GSW Head 8.0 ETT 26 @ 114



DATE	TIME	MODE	RATE	VOLUME	FI02	PEEP	PIP	PT RATE	HR	SO2	BP	Ph	Pco2	Po2	BE	HCO3	SaO2	REMARKS
2 Nov	0230	SIMV	12	700	100	5	23	12	123	100	137/69	7.35	30.7	288	-7	18	100	
	0330	SIMV	12	700	50	5	25	12	100	100	—							
	0500	SIM	12	700	40	5	20	12	85	100	108/56							
	0800	SIMV	↑14	700	40	5	18	14	93	100	125/61							
	1000	SIMV	↑15	700	40	5	17	15	94	100	128/62							
	1330	SIMV	↓13	700	40	5	19	14	93	100	134/73							
	1600	SIMV	13	700	40	5	19	14	104	100	137/73							
	1800	SIMV	13	700	40	5	21	14	110	100	135/70							
	2000	SIMV	13	700	40	5	22	14	112	100	136/69							
	2200	SIMV	13	700	40	5	19	14	111	100	116/75							
	2330	SIMV	13	700	40	5	19	21	121	98	—							
	0140	SIMV	13	700	40	5	20	14	100	100	111/71							
	0400	SIMV	11	700	40	5	17	13	111	100	97/78							
	0500	SIMV	11	700	40	5	18	11	108	100	96/79	7.42	31.4	135	-4	21	99	
	0800	SIMV	11	700	40	5	16	15		100	114/68							
	1000	SIMV	11	700	40	5	15	16	112	100	93/84							
	1230	SIMV	11	700	40	5	21	11	94	100	87/78							
	1400	SIMV	11	700	40	5	21	11	98	100	120/68							
	1600	SIMV	11	700	40	5	18	11	94	100	81/71							
	1800	SIMV	11	700	40	5	18	11	100	100	84/71							
	2130	SIMV	11	700	40	5	20	11	100	100	101/59							
	2340	SIMV	11	700	40	5	21	11	119	100	104/55							
	0200	SIMV	11	700	40	5	19	11	112	100	91/58							
	0400	SIMV	11	700	40	5	19	11	121	100	98/55							
	0600	SIMV	11	700	40	5	21	11	110	100	97/54							
	0900	Pt extubated																
	0000							pre				post						
	0520				RA		20		103	94%	/	23	124	100%				Alb neb given



MEDICAL RECORD | VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR November 19 2003 | DAY 12 13 14 15

HOUR 0800 | 2000 | 1400 | 0800 | 2300 | 0800 | 0800 | 0800

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD 20 | 18 | 16 | 16 | 18 | 16 | 18

Record special data only when so ordered

BLOOD PRESSURE	94/52	105/48	99/48 83	101/56	108/49	99/58	104/45
TEMP	98.0		98.5	97.5			
HEIGHT: WEIGHT TEMP				98%			
O_2 Sat	99%	98(CN)	99%	100%	98(CN)	99%	98(CN)
O_2 Sat				RA		RA	
pulse	84			78			
pulse							

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)*

REGISTER NO. | WARD NO.

STANDARD FORM 511 (REV. 7-95) **BACK**

(b)(6)-4

MEDCOM - 23111

511-119 NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR NOV 2003 — DAY — HOUR

PULSE (O) — TEMP. F (•) — TEMP. C

PULSE	TEMP. F	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99° / 98.6°	37.2° / 37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD

BLOOD PRESSURE

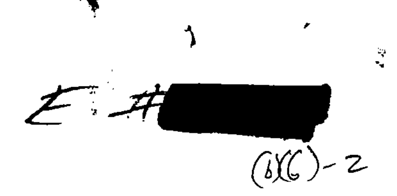
HEIGHT: WEIGHT →

Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO.



(b)(6)-2

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23112

(b)(6)-2 whole page

REQUESTING PHYSICAN: [redacted]

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

DATE	TIME	SSN/PEEUDO SSN:
11-2-03	0800	

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 08:11

Patient ID: [redacted]
Test Name :PT
Test Result:= 15.6 sec.
Ratio = 1.3
Calculated INR = 1.49
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :08:10
Card Lot :080201
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 08:14

Patient ID: [redacted]
Test Name :APTT
Test Result:= 41.9 sec.
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :08:11
Card Lot :030201
Operator [redacted]

Urinalysis

RESULT	REF. RANGE
	N/A
	N/A
	Negative
	Negative
	Negative
	N/A
	Negative
	N/A
	Negative
	0.2-1.0
	Negative
	Negative
	Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

CSF

n		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 23113

ACLU-RDI 1675 p.74

DOD-036690

4 Rx. 18

Ward/Section: 1C03	REQUESTING PHYSICAN: [redacted] (b)(6)-2 (b)(6)-4	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST,MI. [redacted]	DATE 11-2-03 / TIME 800	SSN/PEEUDO SSN:

EG6+

Pt: [redacted]
Pt Name:____________

Na_________141 mmol/L
K__________3.5 mmol/L
TCO2________26 mmol/L
Hct_________20 %PCV
Hb*__________7 g/dL
*via Hct

At 37C
pH_______7.417
PCO2______38.7 mmHg
PO2________173 mmHg
HCO3________25 mmol/L
BEecf________0 mmol/L
sO2*_______100 %
*calculated

At Patient Temp
pH_______7.418
PCO2______38.5 mmHg
PO2________173 mmHg

Patient Temp: 98.4F
FIO2________: 40
Sample Type_:

02NOV03 08:08

Oper: [redacted]
Physician:

Ser# [redacted]
Ver: [redacted]

Left column labels (partially obscured): TE, Na, K, Cl, pH, PC, PO, TC, HC, SO, BE, AnG, Ca, BU, GL, Cre, Hct, Hgb, TE, Trop, Dru Abu, RE, RE

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA+		128-145 mmol/dl
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA+		128-145 mmol/l
K+		3.3-4.7 mmol/l
CL-		98-108 mmol/l
tCO2		18-33 mmol/l

DATE: LAB ID NO.:

MEDCOM - 23114

402 101.1

(b)(6)-4

Ward/Section [redacted]	REQUESTING PHYSICAN: (b)(6)-2 [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI. [redacted]	DATE 11-2-03	TIME 1645	SSN/PEEUDO SSN:

(b)(6)-4

[redacted]

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

TEST	RESULT	REF. RANGE
Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

TEST	RESULT	REF. RANGE
Spun Hematocrit		42-52 %(M) 37-47%(F)
Set Rate		
Other		

CSF

TEST	RESULT	REF. RANGE
Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 23115

ACLU-RDI 1675 p.76

DOD-036692

[handwritten: illegible] 10[illegible]

REQUESTING PHYSICAN:

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

DATE | TIME | SSN/PSEUDO SSN:

i-STAT EG6+

Pt: [redacted]

Pt Name:____________

Na__________143 mmol/L
K__________3.7 mmol/L
TCO2________28 mmol/L
Hct__________23 %PCV
Hb*__________8 g/dL
*via Hct

At 37C

PH_______7.492
PCO2______34.6 mmHg
PO2________159 mmHg
HCO3________26 mmol/L
BEecf________3 mmol/L
sO2*_______100 %
*calculated

At Patient Temp
PH_______7.471
PCO2______36.8 mmHg
PO2________167 mmHg

Patient Temp: 101.1F
FIO2________: 40
Sample Type_:

02NOV03 16:53

Oper: [redacted]

Physician:______________

Ser# [redacted]
Ver: [redacted]

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/dl
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO2		18-33 mmol/l

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 23116

402 101.1

Ward/Section: ICU | **REQUESTING PHYSICIAN:** (b)(6)-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. (b)(6)-4 | **DATE** 11-2-03 | **TIME** 1645 | **SSN/PSEUDO SSN:** 1451

ID
WB
02-11-03
16:54

				Patient Limits	
WBC	10.8	H	x10^3/uL	4.5	10.5
RBC	2.99	L	x10^6/uL	4.00	6.00
Hgb	8.0	L	g/dL	11.0	18.0
Hct	25.2	L	%	35.0	60.0
MCV	84.4		fL	80.0	99.9
MCH	26.8	L	pg	27.0	31.0
MCHC	31.8	L	g/dL	33.0	37.0
Plt	130.	L	x10^3/uL	150.	450.
LY%	14.7	*L	%	20.5	51.1
LY#	1.6	*	x10^3/uL	1.2	3.4

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

Spun Hematocrit		42-52%(M) 37-47%(F)
Set Rate		
Other		

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: | **DATE:** | **LAB ID NO.:**

(b)(6)-2

Ward/Section: ICU

[TE]STING PHYSICIA[N]: [redacted]

[CH]EMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI. [redacted] (b)(6)-4

DATE 11-4-03 | TIME 1400 | SSN/PSEUDO SSN:

101.5
402

(i-STAT)

i-STAT EG6+

Pt: [redacted]
Pt Name:____________

Na__________138 mmol/L
K__________3.3 mmol/L
TCO2________26 mmol/L
Hct_________22 %PCV
Hb*_________7 g/dL
*via Hct

At 37C
PH_______7.534
PCO2______29.3 mmHg
PO2________211 mmHg
HCO3________25 mmol/L
BEecf________2 mmol/L
sO2*_______100 %
*calculated

At Patient Temp
PH_______7.509
PCO2______31.4 mmHg
PO2________219 mmHg

Patient Temp: 101.5F
FIO2________: 40
Sample Type_:

04NOV03 16:27

Oper: [redacted]

Physician:______________

Ser# [redacted]
Ver: [redacted]

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

DATE: [redacted] 4NOV03 | LAB ID NO.:

MEDCOM - 23118

100.7 4

(b)(6)-2

Ward/Section: ICU3	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4	DATE 11-4-03 / TIME 1300	SSN/PSEUDO SSN:

i-STAT EG6+

Pt:

Pt Name:___________

Na_________139 mmol/L
K__________3.5 mmol/L
TCO2________24 mmol/L
Hct_________20 %PCV
Hb*_________7 g/dL
*via Hct

At 37C

PH_______7.503
PCO2______29.4 mmHg
PO2_________95 mmHg
HCO3________23 mmol/L
BEecf________0 mmol/L
sO2*_________98 %
*Calculated

Sample Type_:

04NOV03 13:09

Oper:

Physician:_____________

Ser#

Ver:

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 23119

F [illegible] 25%
35.1 EGT, [illegible] / PT/PTT

Ward/Section: REQUESTING [illegible]

LAST, FIRST, MI: (b)(6)-4

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

DATE: 02 Nov03 TIME: 0030

SSN/PSEUDO SSN:

(Hematology) CBC

Urinalysis

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

WBC
RBC
Hgb
Hct
MCV
Plt
Lymph
(Hem
Segs

ID: [redacted] 02-11-03
WB 00:39

				Patient Limits	
WBC	32.3 H	x10^3/uL		4.5	10.5
RBC	4.02	x10^6/uL		4.00	6.00
Hgb	10.7 L	g/dL		11.0	18.0
Hct	34.3 L	%		35.0	60.0
MCV	85.2	fL		80.0	99.9
MCH	26.7 L	pg		27.0	31.0
MCHC	31.4 L	g/dL		33.0	37.0
Plt	194.	x10^3/uL		150.	450.
LY%	9.4	*L	%	20.5	51.1
LY#	3.0	*	x10^3/uL	1.2	3.4

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
[illegible]		N/A
Bld		Negative
[illegible]		N/A
Prot		Negative
Urob		0.2-1.0
		Negative
		Negative
		Negative

Microbiology

Source	
Gram Stain	
Occ Bld	Negative
H. pylori	Negative
Micro Parasites	
Malaria	
O & P	
Other	

Microscopic Urinalysis

CSF

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

[illegible]ligen Negative

ABO/Rh

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 00:42
Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 17.1 sec.
Ratio = 1.4
Calculated INR = 1.73
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :00:39
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 00:46
Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 35.2 sec.
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :00:43
Card Lot :030201
Operator [redacted] (b)(6)-2

[illegible]E: Nov03 LAB ID NO.:

MEDCOM - 23120

pH 7.387
pCO_2 35.6
pO_2 450
BEecf -4
HCO_3 21
TCO_2 22
SO_2% 100
Na 141
K 2.8
Hct 30
Hb 10

Ward/Section ER

REQUEST... [redacted] (b)(6)-2

LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI # [redacted] (b)(6)-4

DATE 1 Nov | TIME | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

ID: [redacted]
WB

01-11-03
23:44

			Patient Limits	
WBC	32.0 H	x10^3/uL	4.5	10.5
RBC	4.27	x10^6/uL	4.00	6.00
Hgb	11.3	g/dL	11.0	18.0
Hct	35.8	%	35.0	60.0
MCV	83.7	fL	80.0	99.9
MCH	26.4 L	pg	27.0	31.0
MCHC	31.6 L	g/dL	33.0	37.0
Plt	299.	x10^3/uL	150.	450.
LY%	....	%	20.5	51.1
LY#	----	x10^3/uL	1.2	3.4

MC
Plt
Lymph
(H
Segs
Bands
Lymph
Atyp | | Imm |

Urinalysis

TEST	RESULT	REF. RANGE
Color	yel	N/A
App	clr	N/A
Glu	neg	Negative
Bili	neg	Negative
Ket	neg	Negative
SG	1.010	N/A
Bld	sm	Negative
pH	7.5	N/A
Prot	neg	Negative
Urob	neg	0.2-1.0
Nit	neg	Negative
Leuk	neg	Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

igen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh | A pos

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

LAB ID NO.: [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/01/03 23:50

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 16.3 sec.
Ratio = 1.3
Calculated INR = 1.60
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :23:48
Card Lot [redacted]
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/01/03 23:52

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 20.9 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/01/03
Test Time :23:50
Card Lot [redacted]
Operator [redacted] (b)(6)-2

MEDCOM - 23122

(b)(6)-2

Ward/Section: ER	REQUESTING PHYSICIAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI (b)(6)-4	DATE 3 Nov 03 TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmo
K		3.5-4.9 mmol/
Cl		98-109 mmol/
pH		7.31-7.45
PCO2		35-45 mmHg (41-51 mmHg (v
PO2		80-105 mmHg (N/A (ven)
TCO2		23-27 mmol/L (24-29 mmol/L (v
HCO3		22-26 mmol/L (23-28 mmol/L (v
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmo
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST | RESULT | REF

======= PICCOLO =======
01/11/03 23:47
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
LIVER PANEL PLUS
DISC LOT #: 3153AA7
OPER #: DR #: 000
SERIAL #:
....

ALB	3.6	3.3-5.5	G/DL
ALP	52	26-84	U/L
ALT	13	10-47	U/L
AMY	31	14-97	U/L
AST	20	11-38	U/L
TBIL	0.6	0.2-1.6	MG/DL
GGT	<5*	5-65	U/L
TP	6.0*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 1+, LIP 0, ICT 0

(Piccolo) Metabolic Panel

======= PICCOLO =======
01/11/03 23:44
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: DR #: 000
SERIAL #:
....

GLU	217*	73-118	MG/DL
BUN	12	7-22	MG/DL
CRE	1.2	0.6-1.2	MG/DL
CK	127	39-380	U/L
NA+	128	128-145	MMOL/L
K+	3.7	3.3-4.7	MMOL/L
CL-	102	98-108	MMOL/L
tCO2	20	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0, LIP 0, ICT 0

tCO2 | | 18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 23123

(b)(6)-4 (b)(6)-2

Ward/Section: [redacted]	REQUESTING PHYSICAN: [redacted]	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI: 1CW3	DATE: 11/2/03 / TIME	SSN/REFUDO/SSN:

(Hematology) CBC			Urinalysis		
TEST	RESULT	REF RANGE	TEST	RESULT	REF
					N/A
					N/A
					Negati
					Negati
					Negati
					N/A
					Negati
					N/A
					Negati
					0.2-1.(
					Negati
					Negati
					Negati

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 03:01

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.8 sec.
Ratio = 1.3
Calculated INR = 1.52
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :03:00
Card Lot :080201
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 03:04

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 29.3 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :03:01
Card Lot :030201
Operator [redacted] (b)(6)-2

ID: [redacted] 02-11-03
WB 02:58

			Patient Limits	
WBC	23.5 H	x10^3/uL	4.5	10.5
RBC	3.34 L	x10^6/uL	4.00	6.00
Hgb	9.8 L	g/dL	11.0	18.0
Hct	28.4 L	%	35.0	60.0
MCV	85.1	fL	80.0	99.9
MCH	26.4 L	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	181.	x10^3/uL	150.	450.
LY%	....	%	20.5	51.1
LY#	----	x10^3/uL	1.2	3.4

F RANGE
ative
ative
egative
egative

lysis

CSF			Blood Bank	
			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
ntigen		Negative	ABO/Rh	

Blood Bank Unit Crossmatch
MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

APTT		21-34 SESS			
D dimer		<20 ug/ml			
FDP		< 10 ug /ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

ABG T 94.5

MEDCOM - 23124

ACLU-RDI 1675 p.85

DOD-036701

(b)(6)-4 whole page

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

Ward/Section:

REQUESTING PHYSICAN:

LAST, FIRST,MI.

DATE | TIME | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na	142	138-146 mmol/dL
K	3.6	3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.375	7.31-7.45
PCO2	30.7	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	288	80-105 mmHg (art) N/A (ven)
TCO2	19	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	18	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	-7	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct	25	38-51% PCV
Hgb	9	12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE

======= PICCOLO =======
02/11/03 02:56
REFERENCE RANGE: MALE
PATIENT #:
METLYTE 8
DISC LOT #: 3151AA4
OPER #: DR #: 000
SERIAL #:

GLU	213*	73-118	MG/DL
BUN	9	7-22	MG/DL
CRE	1.0	0.6-1.2	MG/DL
CK	173	39-380	U/L
NA+	128	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	109*	98-108	MMOL/L
tCO2	17*	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl

======= PICCOLO =======
02/11/03 02:59
REFERENCE RANGE: MALE
PATIENT #:
LIVER PANEL PLUS
DISC LOT #: 3153AA7
OPER #: DR #: 000
SERIAL #:

ALB	2.7*	3.3-5.5	G/DL
ALP	43	26-84	U/L
ALT	11	10-47	U/L
AMY	37	14-97	U/L
AST	22	11-38	U/L
TBIL	1.7*	0.2-1.6	MG/DL
GGT	9	5-65	U/L
TP	4.4*	6.4-8.1	G/DL

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

MEDCOM - 23125

Ward/Section: 1CW3 | REQUESTING PHYSICAN: (b)(6)-2

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

LAST, FIRST, MI (b)(6)-4 | DATE 11/2/03 | TIME 0535 | SSN/PEEUDO SSN:

(Hematology) CBC			Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
RBC		4.7-6.1 x10	App		N/A	Mono		Negative
Hgb		14-18 g/dl(M) 12-16 g/dl(F)	Glu		Negative	Microbiology		
Hct		42-52%(M) 37-47%(F)	Bili		Negative	Source		
MCV		80-94 fl(M) 81-99 fl(F)	Ket		Negative	Gram Stain		
Plt		130-500 x 10³ verified	SG		N/A	Occ Bld		Negative
Lymph %		20.5-51.1%	Bld		Negative	H. pylori		Negative
(Hematology) Manual Differential			pH		N/A	Micro Parasites		
Segs		Mono	Prot		Negative	Malaria		
					0.2-1.0	O & P		
					Negative	Other		
					Negative	Macroscopic Urinalysis		
					Negative			

CSF			Blood Bank	
			MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED	
tigen		Negative	ABO/Rh	

Blood Bank Unit Crossmatch
MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

E: | LAB ID NO.:

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 05:41

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 15.2 sec.
Ratio = 1.2
Calculated INR = 1.43
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :05:40
Card Lot :080201
Operator : [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/02/03 05:44

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 26.2 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/02/03
Test Time :05:42
Card Lot :030201
Operator : [redacted] (b)(6)-2

ABx

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST,MI.		DATE	TIME		SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH	7.433	7.31-7.45
PCO2	35.2	35-45 mmHg (art) 41-51 mmHg (ven)
PO2	169	80-105 mmHg (art) N/A (ven)
TCO2	24	23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3	23	22-26 mmol/L (art) 23-28 mmol/L (art)
SO2	100	95-98%
BEecf	-1	(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 /l (M) 30-190 /l (F)
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/dl
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AST		14-97 u/l
AMY		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-I		
Drug of Abuse		

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO2		18-33 mmol/l

REMARKS:

REPORTED BY: [redacted]	DATE: 2Nov03	LAB ID NO.:

(b)(6)-2

MEDCOM - 23127

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU 3

REQUESTING PHYSICIAN: [redacted] (b)(6)-2

LAST, FIRST, MI. #[redacted] (b)(6)-4

DATE 11/2/03 TIME 0620

SSN/PSEUDO SSN:

(Hematology) CBC

(b)(6)-4

ID [redacted]			02-11-03	
WB			06:19	
			Patient Limits	
WBC	12.1 H	x10^3/uL	4.5	10.5
RBC	2.85 L	x10^6/uL	4.00	6.00
Hgb	7.6 L	g/dL	11.0	18.0
Hct	24.2 L	%	35.0	60.0
MCV	84.7	fL	80.0	99.9
MCH	26.6 L	pg	27.0	31.0
MCHC	31.4 L	g/dL	33.0	37.0
Plt	127. L	x10^3/uL	150.	450.
LY%	....	%	20.5	51.1
LY#	-----	x10^3/uL	1.2	3.4

RBC Morph		
Spun Hematocrit		42-52%(M) 37-47%(F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: [redacted] (b)(6)-2 DATE: 2 Nov 03 LAB ID NO.:

MEDCOM - 23128

Ward/Section: ICU 3	REQUESTING PHYSICIAN: (b)(6)-2	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4	DATE 11/4/03 TIME 104-	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE

```
i-STAT EG6+
Pt:
Pt Name:

Na________140 mmol/L
K_________3.3 mmol/L
TCO2_______26 mmol/L

*via Hct

37C
pH_______7.483
PCO2______33.3 mmHg
PO2________159 mmHg
HCO3________25 mmol/L
BEecf________1 mmol/L
sO2*_______100 %
*calculated

At Patient Temp
pH_______7.465
PCO2______35.0 mmHg
PO2________166 mmHg

Patient Temp: 100.7F
FIO2________: 40
Sample Type_: ART

04NOV03      10:57

Oper:

Physician:____________

Ser#
Ver:
```

(b)(6)-4

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3mg/dl
CHOL		100-200 mg/dl
CRE		0.6-1.2 mg/dl
GLU		73-118 mg/dl
TP		6.4-8.1 g/dl

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(CN ?

DATE: 4Nov03	LAB ID NO.:

(b)(6)-2

ACLU-RDI 1675 p.90

DOD-036706

Ward/Section:	REQUESTING PHYSICIAN:	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(b)(6)-4

ID: [redacted]
UD

03-11-03
04:46

				Patient Limits	
WBC	11.2	H	x10^3/uL	4.5	10.5
RBC	3.09	L	x10^6/uL	4.00	6.00
Hgb	8.3	L	g/dL	11.0	18.0
Hct	25.9	L	%	35.0	60.0
MCV	83.7		fL	80.0	99.9
MCH	26.9	L	pg	27.0	31.0
MCHC	32.2	L	g/dL	33.0	37.0
Plt	123.	L	x10^3/uL	150.	450.
LY%	16.9	*L	%	20.5	51.1
LY#	1.9	*	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/03/03 04:44

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 14.1 sec.
Ratio = 1.2
Calculated INR = 1.26
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :04:43
Card Lot : [redacted] (b)(6)-2
Operator : [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/03/03 04:47

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 43.7 sec.
RESULT OUT OF RANGE
Sample Type:citrated wh. blood
Test Date :11/03/03
Test Time :04:45
Card Lot : [redacted] (b)(6)-2
Operator : [redacted]

Urinalysis		
TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology		
TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology		
Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF		
Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

DATE:	LAB ID NO.:

MEDCOM - 23130

Ward/Section: ICU 3

REQUESTING PHYSICIAN: (b)(6)-2

LAST, FIRST, MI. (b)(6)-4

CHEMISTRY RESULT FORM

(Subject to the Privacy Act of 1974)

SSN/PSEUDO SSN:

i-STAT

i-STAT EC8+

not ABG sample

Pt:

Pt Name:____________

Glu________110 mg/dL
BUN__________4 mg/dL
Na_________144 mmol/L
*K__________3.0 mmol/L
Cl_________108 mmol/L
TCO2________25 mmol/L
AnGap_______15 mmol/L
Hct_________20 %PCV
Hb*__________7 g/dL
*via Hct
pH_______7.427
PCO2______35.9 mmHg
HCO3________24 mmol/L
BEecf_______-1 mmol/L

Sample Type_:

03NOV03 04:46

Oper:

Physician:_____________

Ser#

Ver:

i-STAT CREA

Pt:

Pt Name:____________

Crea_______1.0 mg/dL

Sample Type_:

03NOV03 04:47

Oper:

Physician:_____________

Ser#

Ver:

(Piccolo) Metlyte 8

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CRE		0.6-1.2 mg/dl
CK		39-380 u/l (M) 30-190 u/l (F)
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

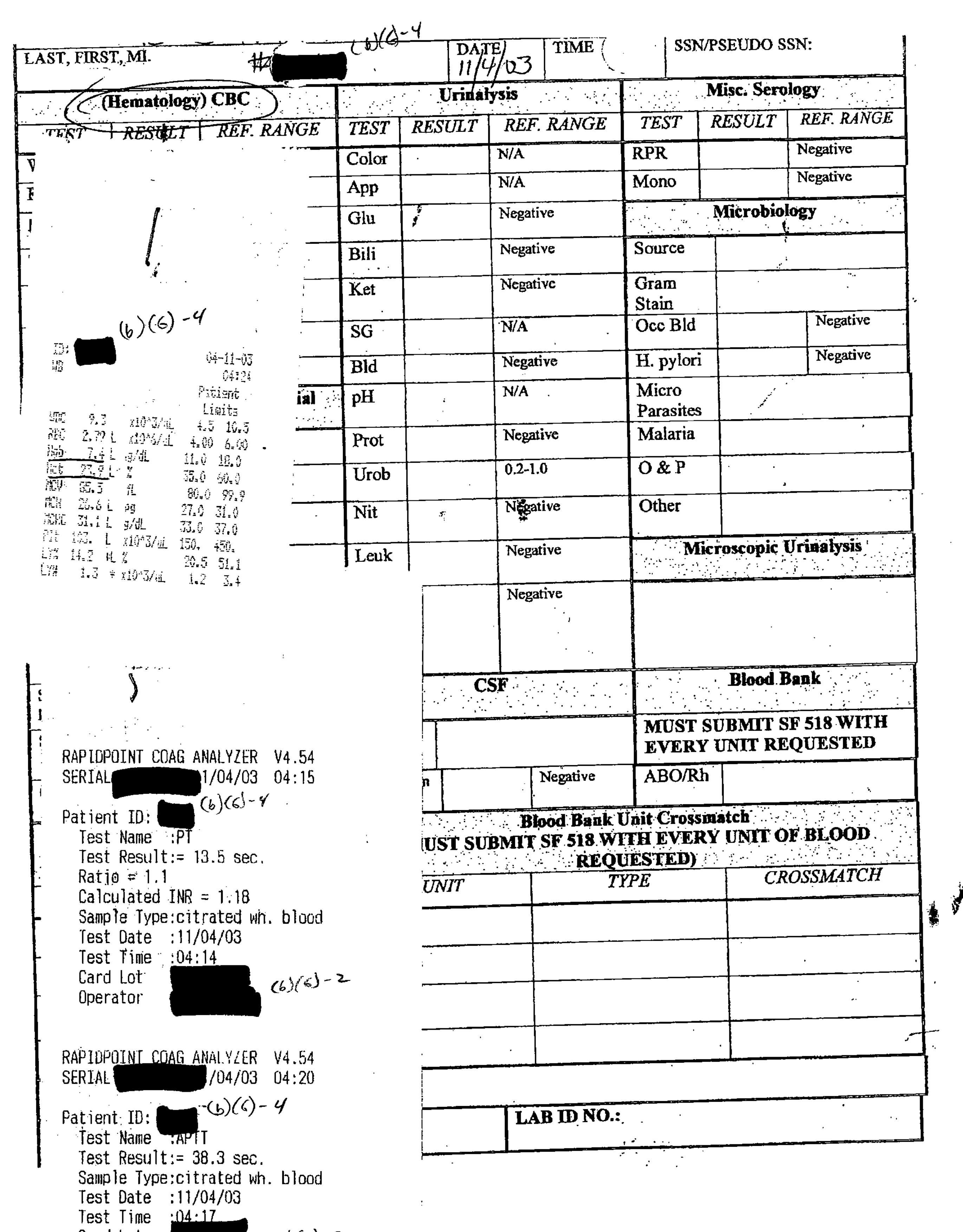
TEST	RESULT	REF. RANGE
NA^+		128-145 mmol/l
K^+		3.3-4.7 mmol/l
CL^-		98-108 mmol/l
tCO_2		18-33 mmol/l

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

ACLU-RDI 1675 p.92

DOD-036708



LAST, FIRST, MI. #[redacted] (b)(6)-4 | DATE 11/4/03 | TIME | SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE

ID: [redacted] (b)(6)-4

04-11-03
04:24

			Patient Limits	
WBC	9.3	x10^3/uL	4.5	10.5
RBC	2.79 L	x10^6/uL	4.00	6.00
Hgb	7.4 L	g/dL	11.0	18.0
Hct	23.9 L	%	35.0	50.0
MCV	85.3	fL	80.0	99.9
MCH	26.6 L	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
PLT	103. L	x10^3/uL	150.	450.
LY%	14.2 HL	%	20.5	51.1
LY#	1.3 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 1/04/03 04:15

Patient ID: [redacted] (b)(6)-4
Test Name :PT
Test Result:= 13.5 sec.
Ratio = 1.1
Calculated INR = 1.18
Sample Type:citrated wh. blood
Test Date :11/04/03
Test Time :04:14
Card Lot [redacted]
Operator [redacted] (b)(6)-2

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] /04/03 04:20

Patient ID: [redacted] (b)(6)-4
Test Name :APTT
Test Result:= 38.3 sec.
Sample Type:citrated wh. blood
Test Date :11/04/03
Test Time :04:17
Card Lot [redacted] (b)(6)-2
Operator

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

n		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh	

Blood Bank Unit Crossmatch
(UST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

LAB ID NO.:

MEDCOM - 23132

ACLU-RDI 1675 p.93

DOD-036709

Ward/Section:	REQUESTING PHYSICIAN:	**CHEMISTRY RESULT FORM** (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
BUN		[illegible]
[illegible]		[illegible]
C[illegible]		[illegible]
C[illegible]		[illegible]
N[illegible]		[illegible]
K[illegible]		[illegible]
CL[illegible]		[illegible]
tC[illegible]		[illegible]

======= PICCOLO =======
04/11/03 04:14
REFERENCE RANGE: MALE
PATIENT #: [redacted] (b)(6)-4
METLYTE 8
DISC LOT #: [redacted] 3151AA4
OPER #: [redacted] DR #: 000
SERIAL #: [redacted]

GLU	115	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	843*	39-380	U/L
NA+	130	128-145	MMOL/L
K+	3.4	3.3-4.7	MMOL/L
CL-	106	98-108	MMOL/L
tCO2	22	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
CRE		0.6-1.2 mg/dl
NA^{+}		128-145 mmol/l
K^{+}		3.3-4.7 mmol/l
CL^{-}		98-108 mmol/l
tCO_2		18-33 mmol/l

(Piccolo) Liver Panel Plus

TEST	RESULT	REF. RANGE
ALB		3.3-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		14-97 u/l
AST		11-38 u/l
TBIL		0.2-1.6 mg/dl
GGT		5-65 u/l
TP		6.4-8.1 g/dl

(Piccolo) Electrolyte

TEST	RESULT	REF. RANGE
[illegible]+		128-145 mmol/l
[illegible]		3.3-4.7 mmol/l
[illegible]		98-108 mmol/l
[illegible]		18-33 mmol/l

REMARKS:

REPORTED BY:	**DATE**

ACLU-RDI 1675 p.94

DOD-036710

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU 3

REQUESTING PHYSICIAN: (b)(6)-2

LAST, FIRST, MI: (b)(6)-4

DATE: 5 Nov 03

TIME: 0430

SSN/PSEUDO SSN:

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
[illegible]		N/A
		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

d		Negative
ri		Negative

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted] 11/05/03 05:27 (b)(6)-4

Patient ID: [redacted]
Test Name :PT
Test Result:= 13.5 sec.
Ratio = 1.1
Calculated INR = 1.18
Sample Type:citrated wh. blood
Test Date :11/05/03
Test Time :05:26
Card Lot [redacted] (b)(6)-2
Operator [redacted]

RAPIDPOINT COAG ANALYZER V4.54
SERIAL [redacted]/05/03 05:30 (b)(6)-4

Patient ID: [redacted]
Test Name :APTT
Test Result:= 40.5 sec.
Sample Type:citrated wh. blood
Test Date :11/05/03
Test Time :05:27
Card Lot [redacted] (b)(6)-2
Operator [redacted]

[redacted] 05-11-03 05:26
Patient Limits

[illegible] 7.0	x10³/µL	4.5	10.5
[illegible] 3.75 L	x10⁶/µL	[illegible]	6.00
[illegible]	g/dL	11.5	18.0
[illegible]	%	35.0	50.0
[illegible] 12.9 L	fL	80.0	99.9
[illegible]	pg	27.0	31.0
[illegible] 31.4 L	g/dL	33.0	37.0
[illegible] 129. L	x10³/µL	150.	450.
[illegible]	%	20.5	51.1
[illegible]	x10³/µL	[illegible]	[illegible]

Microscopic Urinalysis

Blood Bank

SUBMIT SF 518 WITH EVERY UNIT REQUESTED

			ABO/Rh	
[illegible]igen		Negative		

Blood Bank Unit Crossmatch
MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

TEST	RESULT	REF. RANGE
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

REMARKS:

REPORTED BY: | **DATE:** | **LAB ID NO.:**

(b)(6)-4

ID# [redacted] (b)(6)-4 05-11-03 [redacted]
12:35

			Patient Limits	
WBC	9.2	x10^3/uL	4.5	10.5
RBC	2.73 L	x10^6/uL	4.70	6.00
HGB	7.5 L	g/dL	11.0	18.0
HCT	25.9 L	%	35.0	60.0
MCV	[illegible]	fL	80.0	99.9
MCH	27.7	pg	27.0	31.0
MCHC	32.1 L	g/dL	33.0	37.0
PLT	151.	x10^3/uL	150.	450.
LY%	12.5 aL	%	20.5	51.1
LY#	[illegible] aL	x10^3/uL	1.2	3.4

(b)(6)-2

REQUESTING PHYSICAN: [redacted]

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

DATE 11-5-03 | TIME 1330 | SSN/PEEUDO SSN:

CBC

REF. RANGE
4.8-10.8 x10
4.7-6.1 x10
14-18 g/dl(M) 12-16 g/dl(F)
42-52%(M) 37-47%(F)
80-94 fl(M) 81-99 fl(F)
130-500 x 10³ verified
20.5-51.1%

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Macroscopic Urinalysis

Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			
Spun Hematocrit		42-52%(M) 37-47%(F)	
Set Rate			
Other			

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 SESS
D dimer		<20 ug/ml
FDP		< 10 ug /ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

Ward/Section: ICU 3

TESTING PHYSICIAN: (b)(6)-2

LAST, FIRST, MI. (b)(6)-4

DATE 5Nov03 | TIME 0430 | SSN/PSEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/L
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (ven)
sO2		95-98%
BEecf		(-2) – (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Troponin-I		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		
AST		
TBIL		
BUN		
CA^{++}		
CHOL		
CRE		
GLU		
TP		

(Piccolo) Met

TEST	RESULT
GLU	
BUN	
CRE	
CK	
NA^+	
K^+	
CL^-	
tCO_2	

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA^{++}		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/l
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

Panel Plus

REF. RANGE
3.3-5.5 g/dl
26-84 u/l
10-47 u/l
14-97 u/l
11-38 u/l
0.2-1.6 mg/dl
5-65 u/l
5.4-8.1 g/dl

...rolyte

REF. RANGE
128-145 mmol/l
3.3-4.7 mmol/l
98-108 mmol/l
18-33 mmol/l

```
======= PICCOLO =======
05/11/03          05:06
REFERENCE RANGE:    MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #:       3151AA4
OPER #:        DR #: 000
SERIAL #:
.........................
GLU   195*  73-118   MG/DL
BUN     6*  7-22     MG/DL
CRE   0.8   0.6-1.2  MG/DL
CK   4142*  39-380     U/L
NA+   130   128-145  MMOL/L
K+    4.1   3.3-4.7  MMOL/L
CL-   105   98-108   MMOL/L
tCO2   23   18-33    MMOL/L

INST QC: OK    CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

REMARKS:

REPORTED BY: | **DATE:** | **LAB ID NO.:**

MEDCOM - 23136

Ward/Section: ICU 3	REQUESTING PHYSICAN: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI. (b)(6)-4	DATE 6 Nov 03 / TIME 0436	SSN/PEEUDO SSN:

(Hematology) CBC | **Urinalysis** | **Misc. Serology**

TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x10	Color		N/A	RPR		Negative
R			App		N/A	Mono		Negative
H			Glu		Negative	**Microbiology**		
H			Bili		Negative	Source		
M			Ket		Negative	Gram		
I			SG					ative
I			Bld					ative
			pH					
			Prot					
			Urob					
			Nit					
			Leuk					
			HCG					
			Cell Count					H
Other			Directigen					

Coagulation Studies | (MUST SU... | ...OD

TEST	RESULT	REF. RANGE	UNIT
PT		9.8-13.6 secs	
APTT		21-34 SESS	
D dimer		<20 ug/ml	
FDP		< 10 ug /ml	

```
RAPIDPOINT COAG ANALYZER  V4.54
SERIAL #005485  11/06/03  05:44

Patient ID: [redacted] (b)(6)-4
  Test Name   :PT
  Test Result:= 12.9 sec.
  Ratio = 1.1
  Calculated INR = 1.09
  Sample Type:citrated wh. blood
  Test Date   :11/06/03
  Test Time   :05:43
  Card Lot    [redacted] (b)(6)-2
  Operator    :[redacted]
```

```
RAPIDPOINT COAG ANALYZER  V4.54
SERIAL #005485  11/06/03  05:52

Patient ID: [redacted] (b)(6)-4
  Test Name   :APTT
  Test Result:= 32.2 sec.
  Sample Type:citrated wh. blood
  Test Date   :11/06/03
  Test Time   :05:49
  Card Lot    [redacted]
  Operator    [redacted] (b)(6)-2
```

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 23137

Ward/Section:	REQUESTING PHYSICAN:	CHEMISTRY RESULT FORM (Subject to the Privacy Act of 1974)
LAST, FIRST, MI.	DATE / TIME	SSN/PEEUDO SSN:

(i-STAT)

TEST	RESULT	REF. RANGE
Na		138-146 mmol/dL
K		3.5-4.9 mmol/L
Cl		98-109 mmol/L
pH		7.31-7.45
PCO2		35-45 mmHg (art) 41-51 mmHg (ven)
PO2		80-105 mmHg (art) N/A (ven)
TCO2		23-27 mmol/L (art) 24-29 mmol/L (ven)
HCO3		22-26 mmol/L (art) 23-28 mmol/L (art)
SO2		95-98%
BEecf		(-2) - (+3) mmol/L
AnGap		10-20 mmol/L
Ca		1.12-1.32 mmol/L
BUN		8-26 mg/dl
GLU		70-105 mg/dl
Creat		0.7-1.5 mg/dl
Hct		38-51% PCV
Hgb		12-17 g/dl

Misc. Chemistry

TEST	RESULT	REF. RANGE
Tropoin-1		
Drug of Abuse		

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		
AST		
TBII		
BUN		
CA+		
CHO		
CRE		
GLU		
TP		

TES.		
GLU		
BUN		
CRE		
CK		
NA+		
K+		
CL-		
tCO2		

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
E		0.6-1.2 mg/dl
+		128-145 mmol/dl
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

Piccolo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

Piccolo) Electrolyte

RESULT	REF. RANGE
	128-145 mmol/l
	3.3-4.7 mmol/l
	98-108 mmol/l
	18-33 mmol/l

```
======= PICCOLO =======
06/11/03            05:19
REFERENCE RANGE:     MALE
PATIENT #: [redacted] (b)(6)-4
BASIC METABOLIC
DISC LOT #:        3325AA4
OPER #: [redacted]   DR #: 000
SERIAL #: [redacted]
.........................
GLU    140*   73-118    MG/DL
BUN    7      7-22      MG/DL
CA++   7.9*   8.0-10.3  MG/DL
CRE    0.7    0.6-1.2   MG/DL
NA+    137    128-145   MMOL/L
K+     3.9    3.3-4.7   MMOL/L
CL-    109*   98-108    MMOL/L
tCO2   23     18-33     MMOL/L

INST QC: OK     CHEM QC: OK
HEM 0 ,  LIP 0 ,  ICT 0
```

REMARKS:

REPORTED BY:	DATE:

MEDCOM - 23138

ACLU-RDI 1675 p.99

DOD-036715

Ward/Section: ICUS	REQUESTING PHYSICAN: (b)(6)-2	LABORATORY RESULT FORM (Subject to the Privacy Act of 1974)

LAST, FIRST, MI.	DATE	TIME	SSN/PEEUDO SSN:
(b)(6)-4	7/11/2003	0900	

Urinalysis			Misc. Serology		
TEST	RESULT	REF. RANGE	TEST	RESULT	REF. RANGE
Color		N/A	RPR		Negative
App					Negative
Glu			biology		
Bili					
Ket					
SG					Negative
Bld					Negative
pH					
Prot					
Urob					
Nit					
Leuk			opic Urinalysis		
ICG					

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/07/03 05:01

Patient ID: (b)(6)-4
Test Name :PT
Test Result:= 12.6 sec.
RESULT OUT OF RANGE
Ratio = 1.0
Calculated INR = 1.05
Sample Type:citrated wh. blood
Test Date :11/07/03
Test Time :05:00
Card Lot : (b)(6)-2
Operator :

ID: (b)(6)-4
WB

07-11-03
04:55

			Patient Limits	
WBC	10.0	x10^3/uL	4.5	10.5
RBC	2.86 L	x10^6/uL	4.00	6.00
Hgb	7.7 L	g/dL	11.0	18.0
Hct	24.7 L	%	35.0	60.0
MCV	86.5	fL	80.0	99.9
MCH	26.9 L	pg	27.0	31.0
MCHC	31.1 L	g/dL	33.0	37.0
Plt	286.	x10^3/uL	150.	450.
LY%	21.1 *	%	20.5	51.1
LY#	2.1 *	x10^3/uL	1.2	3.4

RAPIDPOINT COAG ANALYZER V4.54
SERIAL #005485 11/07/03 05:04

Patient ID: (b)(6)-4
Test Name :APTT
Test Result:= 33.9 sec.
Sample Type:citrated wh. blood
Test Date :11/07/03
Test Time :05:01
Card Lot : (b)(6)-2
Operator :

ood Bank

ell ount			SMIT SF 518 WITH IIT REQUESTED
rectigen		Negative	ABO/Rh

Blood Bank Unit Crossmatch (MUST SUBMIT SF 518 WITHE EVERY UNIT OF BLOOD REQUESTED)

			UNIT	TYPE	CROSSMATCH
PT		9.8-13.6 secs			
APTT		21-34 SESS			
D dimer		<20 ug/ml			
FDP		<10 ug/ml			

REMARKS:

REPORTED BY:	DATE:	LAB ID NO.:

TING PHYSICAN:

CHEMISTRY RESULT FORM
(Subject to the Privacy Act of 1974)

	DATE	TIME		SSN/PEEUDO SSN:

---

i-STAT EG6+

Pt:

Pt Name:____________

Na_________138 mmol/L
K__________3.6 mmol/L
TCO2________29 mmol/L
Hct_________23 %PCV
Hb*__________8 g/dL
*via Hct

At 37C
PH_______7.395
PCO2______45.3 mmHg
PO2_________54 mmHg
HCO3________28 mmol/L
BEecf________3 mmol/L
sO2*________87 %
*calculated

Sample Type_:

07NOV03 04:51

Oper: 0

Physician:______________

Ser#
Ver:

(Piccolo) Chemistry 12

TEST	RESULT	REF. RANGE
ALB		3.5-5.5 g/dl
ALP		26-84 u/l
ALT		10-47 u/l
AMY		
AST		
TBIL		
BUN		
CA++		
CHOL		
CRE		
GLU		
TP		

(Piccolo) Metabolic Panel

TEST	RESULT	REF. RANGE
GLU		73-118 mg/dl
BUN		7-22 mg/dl
CA++		8.0-10.3 mg/dl
		0.6-1.2 mg/dl
		128-145 mmol/dl
		3.3-4.7 mmol/l
		98-108 mmol/l
		18-33 mmol/l

(Picc...

TEST	R...
GLU	
BUN	
CRE	
CK	
NA+	
K+	
CL-	
tCO2	

...lo) Liver Panel Plus

RESULT	REF. RANGE
	3.3-5.5 g/dl
	26-84 u/l
	10-47 u/l
	14-97 u/l
	11-38 u/l
	0.2-1.6 mg/dl
	5-65 u/l
	6.4-8.1 g/dl

...lectrolyte

REF. RANGE
128-145 mmol/l
3.3-4.7 mmol/l
98-108 mmol/l
18-33 mmol/l

======= PICCOLO =======
11/07/03 16:0= AM
REFERENCE RANGE: MALE
PATIENT #: (b)(6)-4
METLYTE 8
DISC LOT #: 3151AA4
OPER #: DR #: 000
SERIAL #:

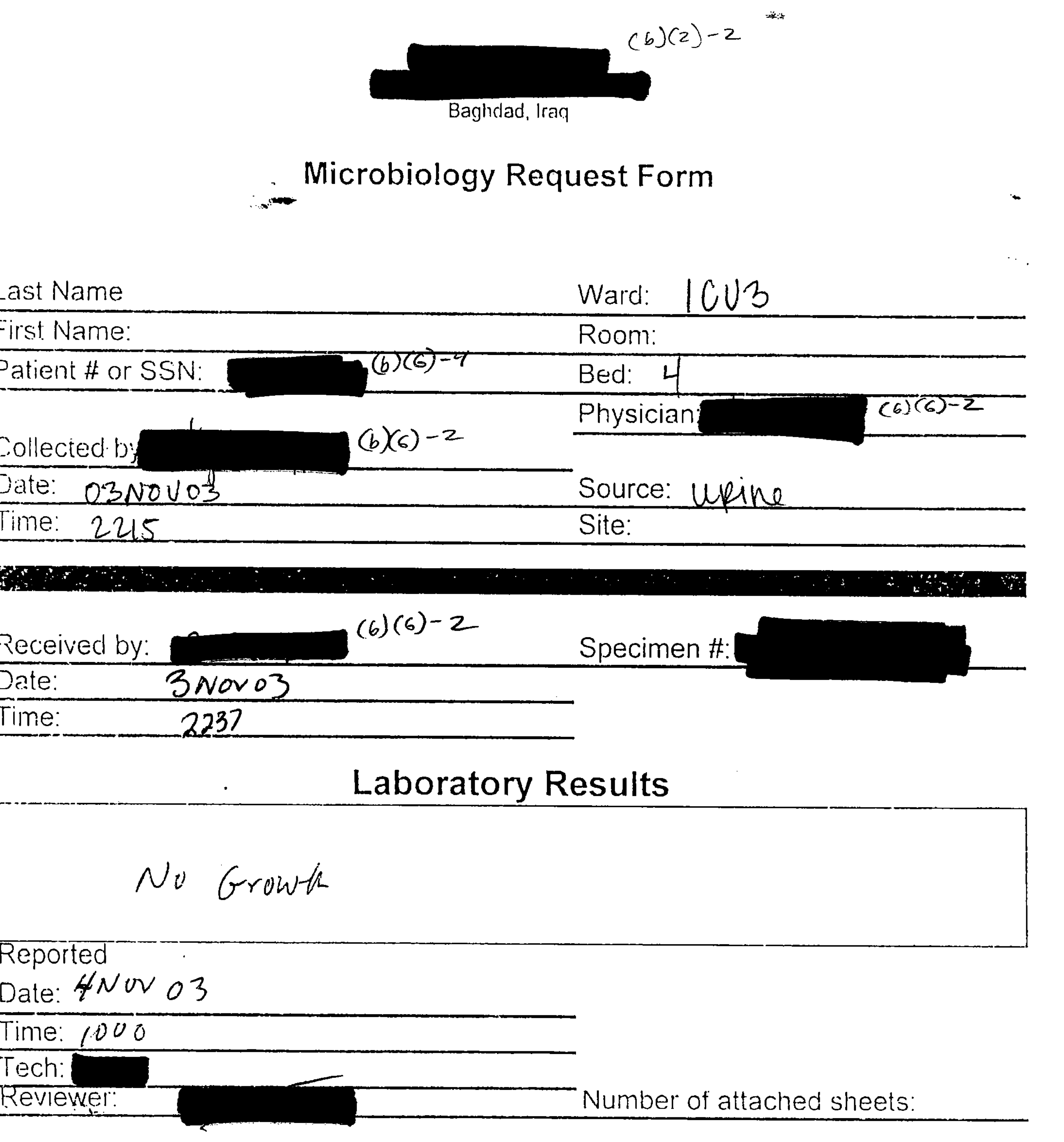
GLU	130*	73-118	MG/DL
BUN	5*	7-22	MG/DL
CRE	1.1	0.6-1.2	MG/DL
CK	1394*	39-380	U/L
NA+	♦♦♦	128-145	MMOL/L
K+	4.0	3.3-4.7	MMOL/L
CL-	95*	98-108	MMOL/L
tCO2	23	18-33	MMOL/L

INST QC: OK CHEM QC: OK
HEM 0 , LIP 0 , ICT 0

REMARKS (b)(6)-2

REPORTED BY:	DATE:	LAB ID NO.:

MEDCOM - 23140



[redacted] (b)(2)-2
Baghdad, Iraq

Microbiology Request Form

Last Name
First Name:
Patient # or SSN: [redacted] (b)(6)-4
Collected by: [redacted] (b)(6)-2
Date: 03NOV03
Time: 2215

Ward: ICU3
Room:
Bed: 4
Physician: [redacted] (b)(6)-2
Source: urine
Site:

Received by: [redacted] (b)(6)-2
Date: 3NOV03
Time: 2237

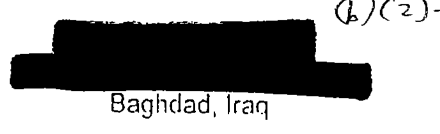
Specimen #: [redacted]

Laboratory Results

No Growth

Reported
Date: 4NOV03
Time: 1000
Tech: [redacted]
Reviewer: [redacted]

Number of attached sheets:



(b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Last Name

First Name:

Patient # or SSN: # (b)(6)-4

Collected by: (b)(6)-2

Date: 03NOV03

Time: 2215

Ward: ICU3

Room:

Bed: 4

Physician: (b)(6)-2

Source: urine

Site:

Received by: SGT (b)(6)-2

Date: 3NOV03

Time: 2237

Specimen #:

Laboratory Results

No Growth

Reported

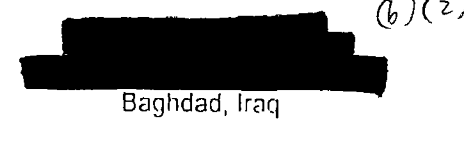
Date: 4NOV03

Time: 1000

Tech:

Reviewer: (b)(6)-2

Number of attached sheets:



(b)(2)-2

Baghdad, Iraq

Microbiology Request Form

Last Name

First Name:

Patient # or SSN: (b)(6)-4

Collected by: (b)(6)-2

Date: 03NOV03

Time: 2230

Ward: ICU3

Room:

Bed: 4

Physician: (b)(6)-2

Source: ~~(R) femoral cordis~~ blood

Site: (R) femoral cordis

Received by: SGT (b)(6)-2

Date: 3 Nov03

Time: 2237

Specimen #:

Laboratory Results

Kluyvera ascorbata

Reported

Date: 7 Nov 03

Time: 1040

Tech (b)(6)-2

Reviewer:

Number of attached sheets:

Microbiology Report (b)(2)-2

Name: (b)(6)-4
Patient ID:
Ward/Rm: U3/

Specimen:
Source: Blood
Ward of Iso:

Status. Final
Collected:
Attd. Phys:

1 Kluyvera ascorbata Status: Final

1 K. ascorbata

Drug	MIC	Interps	Drug	MIC	Interps
Amox/K Clav (c)	>16/8	R			
Amp/Sulbactam (c)	>16/8	R			
Ampicillin	>16	R			
Aztreonam	<=8	S			
Cefazolin	>16	R			
Cefepime	<=8	S			
Cefotaxime (c)	<=8	S			
Cefotetan	<=16	S			
Cefoxitin	>16	R			
Ceftazidime (a)	<=8	S			
Ceftriaxone (c)	<=8	S			
Cefuroxime (b)	<=4	S			
Cephalothin	>16	R			
Chloramphenicol	<=8	S			
Ciprofloxacin	<=1	S			
ESBL-a Scrn	<=4				
ESBL-b Scrn	<=1				
Gatifloxacin	<=2	S			
Gentamicin	<=4	S			
Imipenem (c)	<=4	S			
Levofloxacin	<=2	S			
Meropenem (c)	<=4	S			
Moxifloxacin	<=2	S			
Nitrofurantoin	<=32				
Norfloxacin	<=4				
Pip/Tazo (d)	<=16	S			
Piperacillin (a)	>64	R			
Tetracycline	<=4	S			
Ticar/K Clav (a)	64	I			
Tobramycin	<=4	S			
Trimeth/Sulfa	<=2/38	S			

S = Susceptible
I = Intermediate
R = Resistance
MIC = mcg/ml (mg/L)

N/R = Not Reported
--- = Not Tested
TFG = Thymidine-dependent strain

Blank = Data not available, or drug not advisable or tested
ESBL = Extended spectrum beta-lactamase
Blac = Beta-lactamase positive

R* = Resistant due to extended spectrum beta-lactamases (ESBL)
EBL? = Suspected ESBL Confirmatory tests needed to differentiate ESBL from other beta-lactamases
IB = Inducible Beta-lactamase Appears in place of Sensitive with species known to possess inducible beta-lactamases potentially they may become resistant to all beta-lactam drugs Monitoring of patients during/after therapy is recommended Avoid other/combined beta-lactam drugs

For blood and CSF isolates a beta-lactamase test is recommended for Enterococcus species

(a) Use maximum doses of drug with an aminoglycoside for P aeruginosa in patients with granulocytopenia or serious infections
(b) Breakpoints based on parenteral dose For cefuroxime axetil (PO) use (8=S, 8-16=I, >16=R) Footnote (c) applies to this drug
(c) For streptococci refer to penicillin interpretations For amoxicillin/K clavulanate or ampicillin/sulbactam with enterococci, refer to the penicillin interpretation
(d) For non beta-lactamase producing enterococci refer to the penicillin interpretation Footnote (a) also applies to this drug

Interpretive breakpoints are based on NCCLS M100-S12 Jan 2002 Sparfloxacin (for Gram Negative isolates) and moxifloxacin are based on FDA approved breakpoints
For S pneumoniae cefotaxime and ceftriaxone breakpoints are based on isolates from patients with meningitis For non-meningitis infections use <2=S, 2=I >2=R

- GSW to Parie ? lobe

- allergies ?
- Unknown
Medical Hx
- PSH ?

MEDICAL RECORD - ANESTHESIA

For use of this form, see AR 40-66; the proponent agency is the OTSG

ANESTHETIC AGENTS AND DRUGS

CONTINUOUS/REPEATED DRUGS SPECIFY UNITS - MG/MCG/ML. "I" = CONSTANT INFUSION

DRUG (Units)										TOTALS
Fentanyl (mg)	100	50		100						250
VCB (mg)	6		6			2		2		16
MSO4 (mg)								5	5	10
VOLAT AGENT Iso % del / % e.t.	0.4	1.0	0.8	1.0	0.8	1.0	1.0	1.5	X	
AIR L/Min										
N2O L/Min										
O2 L/Min	2	2	2	2	2	2	2	2	2	

TOTAL EBL: 500

TOTAL URINE: 1100

SINGLE DOSE DRUGS-MARK ON GRID WITH NUMBERS & ENTER IN REMARKS

FLUIDS

LINE site 16G (R) A - Warmed: NS #1 ... 2000
CVL (R) Femoral - Warmed: NS #2 / #3/#4 ... LR #5] 3L
Dilantin 1g - Warmed: IVPB
Warmed: PRBC #1/#2

LOSSES

EST BLOOD LOSS	100	200	300
URINE -	350	PFP / 900	1000

PHYS STATUS: 1 (2) 3 4 5 (E)

BODY WEIGHT: 70 (KG) LB

HEMATOCRIT: 35.8

INITIAL DATA: BP- 150/91; HR- 116

EQUIP CHECK: OK?- (Y) N

PATIENT RECHECK: OK for PROCEDURE? Jr; TIME- 2300

TIME: 0015 · 30 · 45 · 0100 · 30 · 0200 · 30 · 0300

SYMBOLS: BP by cuff V Λ; Heart rate •; Resp rate; BR (transduced); TOURNIQUET T—T; ANES- X-X; PROC- ⊙-⊘

pH 7.39, $PaCO_2$ 35.6, PaO_2 450, BE -4, HCO_3 21, 100; Na 141, K 2.8, 130, 10

ICP mean: 0, 2, 5

VENTIL

VT - ml	620	620	610	780	770	740	760	780	780
f - breaths/min	13	13	13	10	10	10	10	10	10
Peak inf pres / PEEP	15	15	14	17	17	18	17	17	17
MODE - S(pon), A(ssist), C(on)	C	C	C	C	C	C	C	C	C

MONITORS/ACCESSORIES

BP/Auto Cuff; BP/oth; ART line; Steth- PC/ES; Gas analyzer; Warming blkt; Conv warmer

ET CO2 (torr)	26	26	24	24	25	24	26	26	26
FIO2 (Frac or %)	100	.100	0.87	0.86	0.86	0.87	0.89	0.89	0.89
SpO2 (%)	100	100	100	100	100	100	100	100	100
ECG	SR	ST	SR	SR	SR	SR	SR	SR	SR
TEMP-site Nasal	35	35	35.4	34.9	34.4	34	off		
N-M Block (T/4)			0/4	1/4	0/4	0/4	1/4	1/4	

BS +

Room warmed

EVENTS Position: (1) turned 45°

FLUIDS - SUMMARY
CRYSTALLOID- 4L (300 cc / 3700 ...)
COLLOID- 20 Ja
BLOOD- 2 u FFP

REMARKS
Code drugs with numbers, events with letters
(1) EMT intub... CT done to Trauma Ro... Mayfield Ton... in place.
(E) PT- 12.1, INR 1.73, PTT ... 323 / 10.7 / 34.3 / 194
(3) FFP (1) 2451 13, #2 5304284
(4) To ICU-3 c SaO2 ... ICU Monitor ..., Vented SIMV 1, TV 700 ... PS, PEEP + 10, FIO ...

RECOVERY AT: 0310
PACU (ICU) 3 (Specify)
OTHER ICP = 1
CONDITION: Stable vent...
RESP- 12, SpO2- 99, BP- 125/77, HR- 64

ANESTHESIA / PROCEDURE TIMES

	Start	Room	End
ANES	0000	0015	028?
	Ready	Begin	End
PROC	0020	0025	024?

Left margin: PT - 16.3, PTT 20.9, INR 1.6 ... 3 units PRBC's; 11.3/35.8 (299); 138/102/12, 3.7/20/1.2 (217)

PROCEDURES and CPT Codes: Craniotomy: Intraparenchymal evacuation

ANESTHETIC TECHNIQUES: Describe block technique under Remarks: GETA

PATIENT IDENTIFICATION: Typed or written entries: Name, Grade/Rate, Medical facility: POS # [redacted]

AIRWAY MANAGEMENT: Intubation route, blade, technique, comments [redacted] (b)(6)-2

SURGEONS: [redacted] (b)(6)-2

ANESTHETISTS: [redacted] CRNA/MAJ (b)(6)-2

PROCEDURE LOCATION: Traum...

DATE: 11/2/03

PAGE 1 OF 1

(b)(6)-4

MEDCOM - 23145

(b)(6) - 2 except for very bottom

518-124

NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [ ] RED BLOOD CELLS
- [X] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ______ units)*
- [ ] CRYOPRECIPITATE *(Pool of ______ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)*

VOLUME REQUESTED *(If applicable)* 1 unit ML

REMARKS: 16 Mar 04

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN?

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (Head)

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patien[...]en tube label to be corre[...] spc

SI[...]

1 Nov 03

DATE VERIFIED

TIME VERIFIED 0005

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO.

TRANSFUSION NO.

PATIENT NO.

	DONOR	RECIPIENT
ABO	A	A
Rh	pos	pos

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	CMNR

- [X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

REMARKS: ex 3 Nov 03 0140

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

DATE 2 NOV 03

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* 0315 ON *(Date)* 2 NOV 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)*

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION TEMP. 36.1 | PULSE 78 | BP 114/46

DATE OF TRANSFUSION 11/2/03 | TIME STARTED 0335

POST-TRANSFUSION DATA

AMOUNT GIVEN 288 ML

TIME/DATE COMPLETED/INTERRUPTED 0424 11/2/03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 36.9 | PULSE 85 | BLOOD PRESSURE 100/58

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)* NONE

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

SEX M | WARD Emt

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23146

Medical Record Copy

ACLU-RDI 1675 p.107

DOD-036723

518-124 (b)(6)-2 all except those indicated otherwise NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [ ] RED BLOOD CELLS
- [X] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ____ units)
- [ ] CRYOPRECIPITATE (Pool of ____ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ____

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN (Print) [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (Head)

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be co[redacted]

SIGNATURE OF VERIFIER

VOLUME REQUESTED (If applicable): 1 Unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

DATE VERIFIED: 1 Nov 03

TIME VERIFIED: 0005

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ____
HEMOLYTIC DISEASE OF NEWBORN? ____

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4 [redacted]

TRANSFUSION NO. (b)(6)-4

PATIENT NO. [redacted]

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA CNC

PREVIOUS RECORD CHECK: [X] RECORD [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

DONOR	RECIPIENT
ABO A	ABO A
Rh pos	Rh pos

[X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED — DATE 2 Nov 03

REMARKS: exp 3 Nov 03 0100

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY (Signature) [redacted]

AT (Hour) 0100 ON (Date) 02 Nov 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature) [redacted]

2nd VERIFIER (Signature) [redacted] CRNA

PRE-TRANSFUSION TEMP. 35 PULSE 80 BP 132/62

DATE OF TRANSFUSION: 2 Nov 03 TIME STARTED: 0100

POST-TRANSFUSION DATA

AMOUNT GIVEN: all ML

TIME/DATE COMPLETED/INTERRUPTED: 0115 2 Nov 03

REACTION: [X] NONE [ ] SUSPECTED

TEMPERATURE | PULSE | BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
[X] NO [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE [redacted] CRNA

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

\# [redacted] (b)(6)-4

SEX: M WARD: EMT

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23147

(b)(6)-2 except very bottom

518-124

NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [ ] RED BLOOD CELLS
- [X] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ______ units)*
- [ ] CRYOPRECIPITATE *(Pool of ______ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)*

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (Head)

DATE REQUESTED

DATE AND HOUR REQUIRED

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patie[nt an]d the specimen tube label to be corre[ct]. SPC

SIGNA[TURE]

1 Nov 03

DATE VERIFIED

0005

TIME VERIFIED

VOLUME REQUESTED *(If applicable)*: 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

REMARKS: 26 Mar 04

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ______

HEMOLYTIC DISEASE OF NEWBORN? ______

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	CMNR

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

SIG[NATURE OF PERS]ON PERFORMING TEST

	DONOR	RECIPIENT
ABO	A	A
Rh	POS	POS

- [X] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 2 Nov 03

REMARKS:

ex 3 Nov 03
0140

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)* 0315 ON *(Date)* 2 NOV 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER *(Signature)* ... T/AW

2nd VERIFIER *(Signature)*

PRE-TRANSFUSION TEMP. 35.6 PULSE 92 BP 143/71

DATE OF TRANSFUSION 3 Nov 03 TIME STARTED 0335

POST-TRANSFUSION DATA

AMOUNT GIVEN 288 ML

TIME/DATE (COMPLETED)/INTERRUPTED 0448 11/2/03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE 36.9 PULSE 85 BLOOD PRESSURE 105/58

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)* NONE

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; r[ank] rate; hospital or medical facility)

SEX M

WARD Emt

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

MEDCOM - 23148

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

(b)(6)-2 all unless indicated otherwise

518–124 NSN 7540-00-634-4159

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [ ] RED BLOOD CELLS
- [x] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ______ units)*
- [ ] CRYOPRECIPITATE *(Pool of ______ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)*

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [ ] TYPE AND SCREEN
- [ ] CROSSMATCH

DATE REQUESTED

DATE AND HOUR REQUIRED

REQUESTING PHYSICIAN *(Print)*

DIAGNOSIS OR OPERATIVE PROCEDURE: GSW (Head)

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and ... the ... label to be correct.

SIGNATURE OF VERIFIER

VOLUME REQUESTED *(If applicable)*: 1 unit ML

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

DATE VERIFIED: 1 Nov 03

TIME VERIFIED: 0005

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN:

HEMOLYTIC DISEASE OF NEWBORN?

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4

TRANSFUSION NO. (b)(6)-4

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
NA	NA CNR

PREVIOUS RECORD CHECK:

- [x] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST

DONOR

ABO: A

Rh: POS

RECIPIENT

ABO: A

Rh: POS

- [x] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE: 2 NOV 03

REMARKS: exp 3NOV03 0100

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*

AT *(Hour)*: 0100 ON *(Date)*: 02 Nov 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification ...

1st VERIFIER *(Sig...*

2nd ...

PRE-TRA...

TEMP. ...4.1 PULSE 92 BP ...0/42

DATE OF TRANSFUSION: 11/02/03

TIME STARTED: 11/02/03 0115

POST-TRANSFUSION DATA

AMOUNT GIVEN: all ML

TIME/DATE COMPLETED/INTERRUPTED: 1120 02NOV03

REACTION

- [x] NONE
- [ ] SUSPECTED

TEMPERATURE | PULSE | BLOOD PRESSURE

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [x] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle ...; rate; hospital or medical facility)

SEX: M

WARD: Emt

(b)(6)-4

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23149

Medical Record Copy

(b)(6)-2 all except very bottom

EMERGENCY RELEASE OF BLOOD COMPONENTS

SECTION I - REQUISITION

COMPONENTS REQUESTED (Check One)

[X] RED BLOOD CELLS (Crossmatch not performed)

[ ] OTHER (Specify) ______

THE FOLLOWING TESTS HAVE NOT BEEN PERFORMED:
ALANINE AMINOTRANSFERASE; CYTOMEGALOVIRUS TEST; HEPATITIS TESTS; RETROVIRUS TESTS; SYPHILIS SEROLOGY TEST

DUE TO THE CRITICAL CONDITION OF THE BELOW NAMED PATIENT, I REQUEST THE IMMEDIATE RELEASE OF THESE BLOOD PRODUCTS FOR TRANSFUSION WITHOUT COMPLETE TESTING. I UNDERSTAND THE INCREASED RISK TO THE PATIENT AND ACCEPT RESPONSIBILITY FOR THE ADMINISTRATION OF THIS TRANSFUSION.

PHYSICIAN'S SIGNATURE [redacted] DATE 1 Nov 03

SECTION II - ISSUE/TRANSFUSION DATA

TRANSFUSION NUMBER	RECIPIENT ABO/Rh	INS[redacted]	INDIVIDUAL ACCEPTING COMPONENTS
2		AT [redacted] 2340	[redacted] ON (Date) 1 Nov 03

UNIT NUMBER	ABO/Rh	1ST VERIFIER (Signature)	2D VERIFIER (Signature)	DATE/TIME STARTED	DATE/TIME COMPLETED	AMOUNT GIVEN	REACTION YES/NO
ex3Nov [redacted]	O pos	[redacted]		2 Nov 03 2330	2 Nov 03 2340	500 cc	N
ex3 Nov [redacted]	O pos	[redacted]		2 Nov 03 2340	2 Nov 03 2350	500cc	N

IDENTIFICATION VERIFICATION

The transfusionist (1st Verifier) must examine the blood bag label, tag and emergency release form to ensure that it matches the patient's name or trauma number on his/her ID bracelet. He/She must sign the emergency release form in the "1st Verifier" block above to indicate that the correct patient identification was made and to document who started the transfusion. The SECOND individual (2d Verifier) must confirm that positive identification of the patient and the blood unit was made by the transfusionist and must sign the form in the "2d Verifier" block.

TRANSFUSION REACTION

If reation is SUSPECTED - IMMEDIATELY:

1. Discontnue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. DO NOT disgard unit. Return Blood Bag, Filter Set and I.V. solution to the Blood Bank.

Description: [ ] URTICARIA [ ] CHILL [ ] FEVER [ ] PAIN [ ] OTHER ______

OTHER DIFFICULTIES (EQUIPMENT, CLOTS, ETC.) [ ] NO [ ] YES (SPECIFY) ______

SIGNATURE OF PERSON NOTING ABOVE

PRE-TRANSFUSION TEMP: PULSE: B/P:

PREPARED BY (Signature & Title) Lt [redacted] RN | WARD EMT | DATE 2 Nov 03

PATIENT'S IDENTIFICATION (NAME- LAST, FIRST; SSN) [redacted] (b)(6)-4

One copy is placed in the medical records. One copy is return to the blood bank. Red, Purple or Pink top should be drawn and submitted to lab for retroactive crossmatch.

MEDCOM - 23150

518-123 (b)(6)-2 except very bottom

NSN 7540-00-634-4158

MEDICAL RECORD | BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED *(Check one)*

- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS *(Pool of ______ units)*
- [ ] CRYOPRECIPITATE *(Pool of ______ units)*
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER *(Specify)* ______

TYPE OF REQUEST *(Check ONLY if Red Blood Cell Products are requested.)*

- [X] TYPE AND SCREEN
- [X] CROSSMATCH

REQUESTING PHYSICIAN *(Print)*: [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE: S/P GSW to liver

DATE REQUESTED: 05 NOV 03

DATE AND HOUR REQUIRED: 0940

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

VOLUME REQUESTED *(If applicable)*: 1 unit (#2) ML.

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION *(Specify)*

SIGNATURE OF VERIFIER: [redacted]

REMARKS:

IF PATIENT IS FEMALE, IS THERE HISTORY OF:

RhIG TREATMENT? DATE GIVEN: ______

HEMOLYTIC DISEASE OF NEWBORN? ______

DATE VERIFIED: 05 NOV 2003

TIME VERIFIED: 0940

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. (b)(6)-4 [redacted]

TRANSFUSION NO.

PATIENT NO.

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Comp

PREVIOUS RECORD CHECK:

- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST: [signature]

	DONOR	RECIPIENT
ABO	A	A
Rh	pos	pos

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 5 NOV 03

REMARKS: Exp: 6 NOV 03 @ 2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

INSPECTED AND ISSUED BY *(Signature)*: [redacted]

AT *(Hour)* 1207 ON *(Date)* 5 NOV 03

IDENTIFICATION

I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The reci[redacted] same person named on this Blood Component Transfusion Form and on th[redacted]fication tag.

1st [redacted] e) 1 [illegible]

2n[redacted] [illegible]

PRE-TRANSF[redacted]

TEMP. [redacted] 128 BP 94/57

DATE OF TRAN[redacted] 05 NOV [redacted]

TIME STARTED 1215

POST-TRANSFUSION DATA

AMOUNT GIVEN 300 ML

TIME/DATE COMPLETED/INTERRUPTED 05 NOV 03

REACTION

- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.9	132	100/53

If reaction is suspected—IMMEDIATELY:

1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION

- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER *(Specify)*

OTHER DIFFICULTIES *(Equipment, clots, etc.)*

- [X] NO
- [ ] YES *(Specify)*

SIGNATURE OF PERSON NOTING ABOVE: [redacted] [illegible]

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, fi[redacted] middle; grade; rank; rate; hospital or medical facility)

SEX M

WARD ICU

(b)(6)-4 [redacted]

BLOOD OR BLOOD COMPONENT TRANSFUSION

Medical Record

STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23151

(b)(6)-2 except very bottom

518-123 NSN 7540-00-634-4158

MEDICAL RECORD

BLOOD OR BLOOD COMPONENT TRANSFUSION

SECTION I – REQUISITION

COMPONENT REQUESTED (Check one)
- [X] RED BLOOD CELLS
- [ ] FRESH FROZEN PLASMA
- [ ] PLATELETS (Pool of ______ units)
- [ ] CRYOPRECIPITATE (Pool of ______ units)
- [ ] Rh IMMUNE GLOBULIN
- [ ] OTHER (Specify) ______

VOLUME REQUESTED (If applicable) 1 unit (H1) ML

REMARKS:

TYPE OF REQUEST (Check ONLY if Red Blood Cell Products are requested.)
- [X] TYPE AND SCREEN
- [X] CROSSMATCH

DATE REQUESTED 0940

DATE AND HOUR REQUIRED 5 NOV 03

KNOWN ANTIBODY FORMATION/TRANSFUSION REACTION (Specify)

IF PATIENT IS FEMALE, IS THERE HISTORY OF:
RhIG TREATMENT? DATE GIVEN: ______
HEMOLYTIC DISEASE OF NEWBORN? ______

REQUESTING PHYSICIAN (Print) [redacted]

DIAGNOSIS OR OPERATIVE PROCEDURE s/p GSW to liver

I have collected a blood specimen on the below named patient, verified the name and ID No. of the patient and verified the specimen tube label to be correct.

SIGNATURE OF VERIFIER [redacted]

DATE VERIFIED 05 Nov 03

TIME VERIFIED 0940

SECTION II – PRE-TRANSFUSION TESTING

UNIT NO. [redacted]

TRANSFUSION NO.

PATIENT NO.

DONOR ...S

RECIPIENT
ABO A
Rh POS

TEST INTERPRETATION

ANTIBODY SCREEN	CROSSMATCH
	Comp

PREVIOUS RECORD CHECK:
- [X] RECORD
- [ ] NO RECORD

SIGNATURE OF PERSON PERFORMING TEST [redacted]

- [ ] CROSSMATCH NOT REQUIRED FOR THE COMPONENT REQUESTED

DATE 5 Nov 03

REMARKS: Exp 6 Nov 03 @ 2359

SECTION III – RECORD OF TRANSFUSION

PRE-TRANSFUSION DATA

AND ISSUED BY (Signature) [redacted]

AT (Hour) 1106 ON (Date) 5 Nov 03

IDENTIFICATION
I have examined the Blood Component container label and this form and I find all information identifying the container with the intended recipient matches item by item. The recipient is the same person named on this Blood Component Transfusion Form and on the patient identification tag.

1st VERIFIER (Signature) 1CT...

PRE-TRANSFUSION TEMP. 102.+ PULSE 1... BP 84/...

DATE OF TRANSFUSION 11/5/03 TIME STARTED 11...

POST-TRANSFUSION DATA

AMOUNT GIVEN 350 ML

TIME/DATE COMPLETED/INTERRUPTED 05 Nov 03 1205

REACTION
- [X] NONE
- [ ] SUSPECTED

TEMPERATURE	PULSE	BLOOD PRESSURE
100.7	13...	94/47

If reaction is suspected—IMMEDIATELY:
1. Discontinue transfusion, treat shock if present, keep intravenous line open.
2. Notify Physician and Transfusion Service.
3. Follow Transfusion Reaction Procedures.
4. Do NOT discard unit. Return Blood Bag, Filter Set, and I.V. Solutions to the Blood Bank.

DESCRIPTION OF REACTION
- [ ] URTICARIA
- [ ] CHILL
- [ ] FEVER
- [ ] PAIN
- [ ] OTHER (Specify)

OTHER DIFFICULTIES (Equipment, clots, etc.)
- [X] NO
- [ ] YES (Specify)

SIGNATURE OF PERSON NOTING ABOVE [redacted] 1CT/R

PATIENT IDENTIFICATION—USE EMBOSSER (For typed or written entries give: Name—Last, first, middle; grade; rank; rate; hospital or medical facility)

[redacted]

(b)(6)-4

SEX MALE

WARD 1C03

BLOOD OR BLOOD COMPONENT TRANSFUSION
Medical Record
STANDARD FORM 518 (REV. 9-92)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1

MEDCOM - 23152

(b)(6)-2 all unless indicated otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION

(b)(6)-4

NURSING UNIT | ROOM NO. | BED NO.

DATE OF ORDER: 11/2/03 TIME OF ORDER: 0241 HOURS

LIST TIME ORDER NOTED AND SIGN

1. Admit ICU
2. Dx: S/P GSW Head w/ (L) f-Temporal
3. Craniotomy & evacuation of depressed open skull fracture.
4. Vital q1° of neuro v/s.
5. NKDA
6. IV D5 0.9NS w/ 20KCL @ 125 cc
7. MEDS: Ancef 1gm IVPB q8°
   Propofol drip prn sedation
   Dilantin 100mg IVPB q8°
   Zantac 50mg IVPB q8°
8. Foley to gravity
9. I/O's
10. CBC, Chem 7, ABG qd
11. Ventilator: RR 12
    FiO2: 100%
    mode SIMV
    PEEP: 5mm Hg
12. ABG now CO2 30-35
13. ICP call if > 20
14. Ventric @ 6 cm above EAC
15. Tx 2u FFP; ✓ PT/PTT keep INR < 1.2

DATE OF ORDER TIME OF ORDER HOURS

NURSING UNIT | ROOM NO. | BED NO.

24 hr CC Done 11/3/03 @ 0100

DA FORM 4256, 1 APR 79 REPLACES EDITION OF ... WHICH MAY BE USED.

MEDCOM - 23153

(b)(6)-2 all unless indicated otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 11/03/03 TIME OF ORDER 1206 HOURS

LIST TIME ORDER NOTED AND SIGN

① Fentanyl titrate prn agitation/pain

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 11/03/03 TIME OF ORDER 12 05 HOURS

① Tylenol 650 mg per rectum/NG q4h PRN fever

~~V.O. Dr Arm~~ error

② Ventriculostomy 10cm above EAC

V.O. Dr

NURSING UNIT | ROOM NO. | BED NO.

24 hr cc Done 11/03/03 @ 0900

PATIENT IDENTIFICATION 11/03/03

DATE OF ORDER 11/3/03 TIME OF ORDER HOURS

① Attempt to wean w/ lightening sedation.

② 20 meq KCL 4°

~~250cc~~

NURSING UNIT | ROOM NO. | BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER 11/3/03 TIME OF ORDER 2205 HOURS

① Blood & Urine Culture x1 NOW

② Zosyn 3.375 gm IVPB q6°

11/3/03 2210

6121824

NURSING UNIT | ROOM NO. | BED NO.

DA FORM 4256, 1 APR 79 REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 23154

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4		4 NOV 2003 — 1200 HOURS	
		T.O.	
	1	D/C all sedation/analgesics	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION (b)(6)-4		DATE OF ORDER / TIME OF ORDER 1600 HOURS	1600
	1	Per V/O Dr. [redacted] neb treatment @ 1600. V/O Read back LT Beeper	
Noted		T.O. 04 NOV 2003 1713	
	1	1mg Ativan IVP x1 now for agitation	
NURSING UNIT / ROOM NO. / BED NO.		[redacted]	..., MC
PATIENT IDENTIFICATION (b)(6)-4		DATE OF ORDER 11/4/03 TIME OF ORDER	
Noted	1	D/C NG tube	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER 11-5-03 TIME OF ORDER 1730 HOURS	
		T.O.	
		① transfuse 2 units pRBC - clear	1000 5 Nov 03
		② advance diet to clears -	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 23155

(b)(6)-2 unless indicated otherwise

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER	LIST TIME ORDER NOTED AND SIGN
(b)(6)-4		DATE OF ORDER: 6 Nov 03 — TIME OF ORDER: 1735 HOURS	
		V.O. from	
	1	D/C Ancef	
	2	D/C Femoral Cordis	
	3	↑ Clear Liquid	
	4	∅ Nasal	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER: 6 Nov 03 — TIME OF ORDER: 1815 HOURS	
		V.O from TAKEN BY	
	1	- Femoral Cordis line may still be used.	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER — TIME OF ORDER: HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION		DATE OF ORDER — TIME OF ORDER: HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 23156

(b)(6)-2 unless otherwise indicated

CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION (b)(6)-4

DATE OF ORDER 11/7/03 TIME OF ORDER 0913 HOURS

LIST TIME ORDER NOTED AND SIGN

(1). Transfer To ICW-1
(2). Dx: (L) Penetrating Head Injury
Depressed Skull Fracture.
(3). Stable
(4). Vitals q 4°
(5). NPO
(6). D/c Femoral line / D/c Ancef D/c IV

NURSING UNIT ICW 1 ROOM NO. BED NO.

PATIENT IDENTIFICATION

DATE OF ORDER TIME OF ORDER HOURS

(7) Advance Diet as Tolerated
(8). MEDS: Dilantin 300mg po qhs
Zantac 150mg po BID
(9). D/c Foley
(10). Ambulate w/ assistance
(11). D/c Zosyn

1200

NURSING UNIT ROOM NO. BED NO.

24° / 0200 8NOV03

PATIENT IDENTIFICATION

DATE OF ORDER 11/8/03 TIME OF ORDER HOURS

(1) Ambulate w/ assistance.

Noted 0030 9NOV03

NURSING UNIT ROOM NO. BED NO.

24° / 0030 9NOV03

PATIENT IDENTIFICATION

DATE OF ORDER 11/10/03 TIME OF ORDER HOURS

(1) OOB ambulate w/ (R) arm exercises.
(2) Vioxx 50mg po qd.
(3) D/c Dilantin
(4) Incentive Spir...

Noted 10NOV03 1835

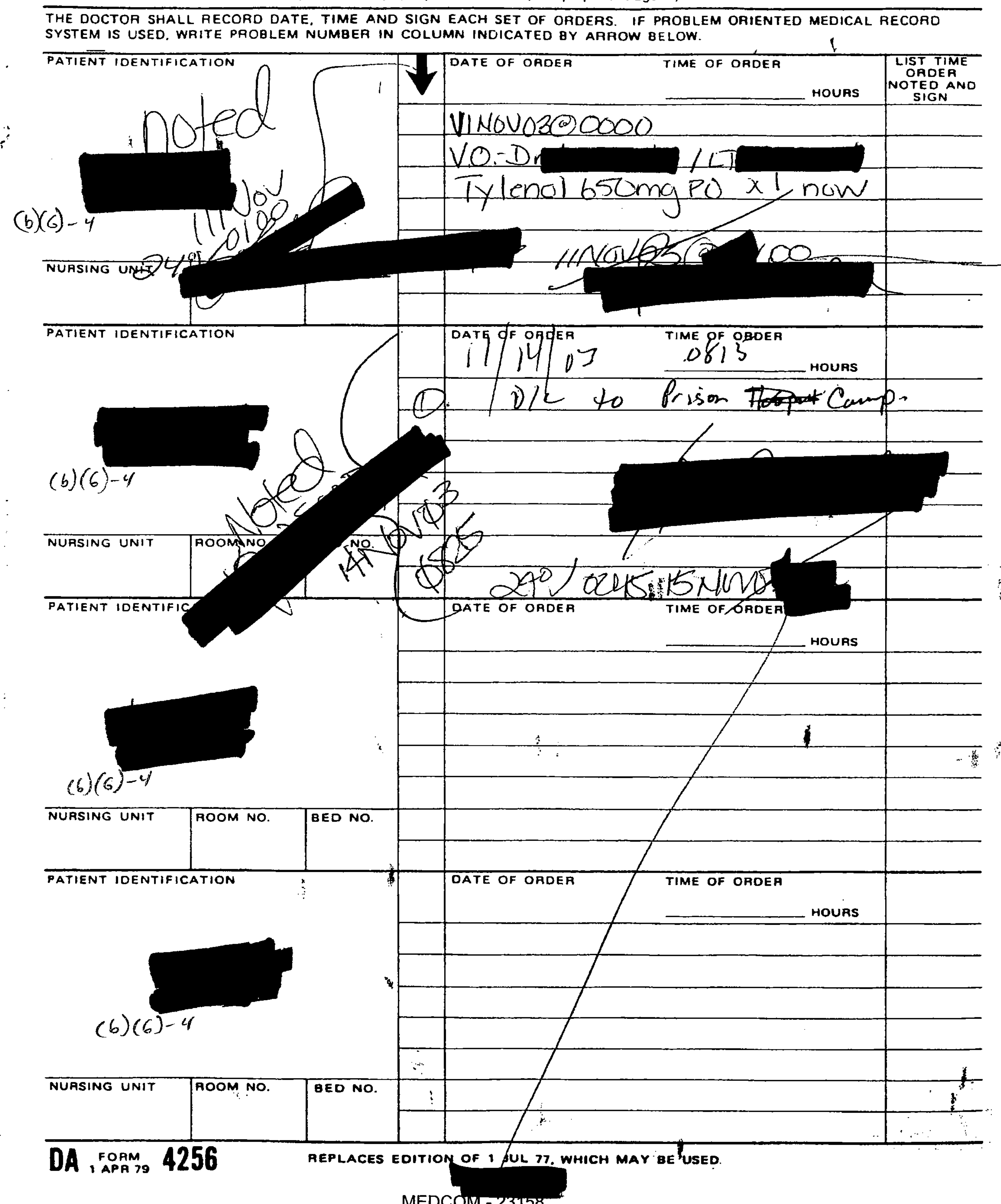
NURSING UNIT ROOM NO. BED NO.

24° 1900 10NOV03 ...TIAN

DA FORM 1 APR 79 **4256** REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 23157

(b)(6)-2 unless otherwise indicated



CLINICAL RECORD - DOCTOR'S ORDERS

For use of this form, see AR 40-66, the proponent agency is OTSG

THE DOCTOR SHALL RECORD DATE, TIME AND SIGN EACH SET OF ORDERS. IF PROBLEM ORIENTED MEDICAL RECORD SYSTEM IS USED, WRITE PROBLEM NUMBER IN COLUMN INDICATED BY ARROW BELOW.

PATIENT IDENTIFICATION	↓	DATE OF ORDER / TIME OF ORDER ___ HOURS	LIST TIME ORDER NOTED AND SIGN
noted (b)(6)-4 11 NOV 0100 24°		11NOV03@0000	
		V.O.: Dr [redacted] / LT [redacted]	
		Tylenol 650mg PO x1 now	
		11NOV03@0100 [redacted]	
NURSING UNIT			
PATIENT IDENTIFICATION (b)(6)-4 Noted 14 NOV 03 0825		DATE OF ORDER 11/14/03 TIME OF ORDER 0815 HOURS	
	①	D/C to Prison ~~Hospit~~ Camp.	
		[redacted]	
NURSING UNIT / ROOM NO. / BED NO.		24° / 0245 15NOV03 [redacted]	
PATIENT IDENTIFICATION (b)(6)-4		DATE OF ORDER / TIME OF ORDER ___ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			
PATIENT IDENTIFICATION (b)(6)-4		DATE OF ORDER / TIME OF ORDER ___ HOURS	
NURSING UNIT / ROOM NO. / BED NO.			

DA FORM 4256, 1 APR 79 — REPLACES EDITION OF 1 JUL 77, WHICH MAY BE USED.

MEDCOM - 23158

ACLU-RDI 1675 p.119

DOD-036735

(b)(6)-2 except for very bottom

CLINICAL RECORD — **THERAPEUTIC DOCUMENTATION CARE PLAN** *(NON-MEDICATION)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. 11 *Yr.* 2003

VERIFY BY INITIALING — *INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION*

ORDER DATE	CLERK/ NURSE	RECURRING ACTIONS, FREQUENCY, TIME	HR	DATE COMPLETED
				1 2 3 4 5 6 7
2 nov 03		Vitals q1° ē neuro	06	C/D 0910 11/7/03
		✓'s	18	
2 nov 03		Foley to gravity	06	D/C 11/7/03 0910
			18	
2 nov 03		I/O's	06	
		~~CBC/PT/PTT/chem7~~	18	
		~~ABG qD~~		
2 nov 03		CBC/PT/PTT/chem7	04	
		ē ABG qD		
2 nov 03		vent: RR 12, FiO2 100%	06	
		SIMV Peep 5	18	D/C'd 4 Nov 03
2 nov 03		Keep CO_2 30-35	06	
			18	
2 nov 03		ICP call HO if >20	06	D/C'd 5 Nov 03
			18	
2 nov 03		Ventric. @ 6cm above	06	D/C'd 3 nov 03
		EAC	18	
3 nov 03		Ventriculostomy @	06	D/C'd 5 Nov 03
		10cm above EAC	18	
11/5/03		ADAT (to clears)	06	x——x
			18	x——x

ALLERGIES: ☐ YES ☐ NO — NKDA

PRIMARY DIAGNOSIS: s/p GSW head w/ Ⓛ F-Temporal craniotomy ē evacuation of depressed open skull fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO:

PATIENT IDENTIFICATION: EPW

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677, 1 OCT 78 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

MEDCOM - 23159

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION)	Mo 11	Yr 2003		
Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
2 Nov 03	[redacted]	Tx 2 u FFP; ✓ PT/PTT keep INR	2 Nov 03	ASAP	0448	[redacted] (b)(6)-2
	-----	< 1.2				
2 Nov 03	[redacted]	ABG Now	2 Nov 03	ASAP	0320	
3 Nov 03	[redacted]	Blood and Urine Culture Now	3 Nov	Now	2235	
4 Nov 03	[redacted]	D/C NG tube	4 Nov 03		[illegible]	

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION TIME/DATE COMPLETED
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USAPA V1.00

MEDCOM - 23160

ACLU-RDI 1675 p.121

DOD-036737

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (NON-MEDICATION) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo Nov Yr. 2003

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH COMPLETION

ORDER DATE	CLERK/ NURSE	RECURRING ACTION, FREQUENCY, TIME	HR	DATE COMPLETED 7	8	9	10	11	12	13	14	15				
7 Nov		Vitals: q 4°	6	/									(b)(6)-2			
			10	/												
			14													
			18													
			22													
			2													
7 Nov		Diet: Advance as tolerated	6													
			12													
			18													
7 Nov		Ambulate c assistance	6										DOB			
			18													
10 Nov 03		OOB ambulate c̄ (P)	06 18	—	—	/										
		arm exercises	18 06	—	—	/										
10		Incentive spirometry	06 18	—	—	/										
			18 06	—	—	/										

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS: ① head injury, depressed skull fx.

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO: ____

PATIENT IDENTIFICATION:

E# (b)(6)-4

ACTION TIMES
USE PENCIL. CIRCLE ACTION TIMES

D	8	9	10	11	12	13	14	15
E	16	17	18	19	20	21	22	23
N	24	01	02	03	04	05	06	07

DA FORM 4677-1, OCT 78 — MEDCOM - 23161 — EDITION OF 1 DEC 77 MAY BE USED. — USAPA V1.00

(b)(6)-2 all

THERAPEUTIC DOCUMENTATION CARE PLAN
(NON-MEDICATION)

Mo NOV Yr 2003

Verity by Initialing: Order Date	Clerk Nurse	SINGLE ACTIONS	Date to be Done	Time to be Done	Time Done	Initials
7 NOV	[redacted]	Transfer ICW-1 Stable	7 NOV	—	—	[redacted]
7 NOV	[redacted]	D/C Femoral line / D/C Art, IV	7 NOV	—	—	[redacted]
	----	Foley, Zosyn	/	/	/	/
14 NOV	[redacted]	DC to prison camp	15 NOV	—	—	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN ACTION, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING COMPLETION — TIME/DATE COMPLETED
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USAPA V1.00

MEDCOM - 23162

(b)(6)-2 for all except the very bottom

CLINICAL RECORD	THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS) For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.	Mo. 11 Yr. 03

VERIFY BY INITIALING — INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED
2 NOV 03	[redacted]	IVF D5 0.9 NS ē 20	06	2 3 4 5 6 7 — D/C 11/7/03 950 [redacted]
		KCL @ 125cc/hr	18	
2 NOV 03	[redacted]	Ancef 1 GM IVPB	06	4 Nov 03
		q8h	14	
			22	
2 NOV 03	[redacted]	Propofol drip	06	
		sedation	18	D/C'd 4 Nov 03
2 NOV 03	[redacted]	Dilantin [redacted] 100mg	06	
		IVPB q8h	14	CHANGED 11/7/03 950
			22	
2 NOV 03	[redacted]	Zantac 50 mg	06	
		IVPB q8	14	CHANGED
			22	11/7/03 950 [redacted]
3 NOV 03	[redacted]	Fentanyl titrate	06	
		PRN agitation/pain	18	[redacted] 03
3NOV03	[redacted]	Attemp to wean w/	06	
		lighting sedation	18	
3NOV03	[redacted]	Zosyn 3.375 gm IVPB	06	
		q6°	12	11/7/03
			18	950 [redacted]
			24	
4NOV	[redacted]	Neb treatments Q6°	06	
			12	
			18	
			24	

ALLERGIES: ☐ YES ☐ NO
NKDA

PRIMARY DIAGNOSIS: S/P GSW Head w/ (L) F-Temporal Craniotomy; evacuation of depressed open skull fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. ______

PATIENT IDENTIFICATION:
EPW
[redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL. CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 4678, 1 FEB 79 — EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED. — USAPA V1.00

MEDCOM - 23163

(b)(6)-2 all

THERAPEUTIC DOCUMENTATION CARE PLAN
(MEDICATIONS)

Verify by Initialing

Mo. Nov Yr. 03

Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
11/3/03	[redacted]	20 mEq KCl IV over 4° 250cc NS	11/3/03	ASAP	1500	[redacted]
11/4/03	[redacted]	1mg Ativan IVP x 1 now for agitation	11/4/03	—	2200	[redacted]
	-----	Transfer 2 [illegible]	11/5/03	1000	1000	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION — TIME/DATE DISPENSED
3 Nov 03	[redacted]	Tylenol 650 mg per rectum/NGT q4h PRN fever	3 Nov 0010; 3 Nov 0600; 2200; 1300; 1400; 5 Nov 2100; 6 Nov 1025; 6 Nov 1145 [initials redacted]
-----	-----		
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USAPA V1.00

MEDCOM - 23164

(b)(6) - 2 except for very bottom

CLINICAL RECORD

THERAPEUTIC DOCUMENTATION CARE PLAN *(MEDICATIONS)*
For use of this form, see AR 40-407; the proponent agency is the Office of The Surgeon General.

Mo. Nov Yr. 03

VERIFY BY INITIALING | *INITIAL PROPER COLUMN FOLLOWING EACH ADMINISTRATION*

ORDER DATE	CLERK/ NURSE	RECURRING MEDICATIONS, DOSE, FREQUENCY	HR	DATE DISPENSED 7	8	9	10	11	12	13	14	15					
7 Nov	- [redacted]	Dilantin 300mg q HS	22	[redacted]		DC 10 Nov 03											
	-----																
7 Nov	- [redacted]	Zantac 150mg PO	10	/	[redacted]												
	-----	BID	22	[redacted]													
10 Nov 03	- [redacted]	Vioxx 50mg PO QD	10	/	/	/	[redacted]										

ALLERGIES: ☐ YES ☒ NO
NKDA

PRIMARY DIAGNOSIS:
1) head injury
depressed skull fx

ADDITIONAL PAGES IN USE: ☐ YES ☐ NO
PAGE NO. ______

PATIENT IDENTIFICATION:
E# [redacted] (b)(6)-4

DISPENSING TIMES

USE PENCIL, CIRCLE MED TIMES

D	7	8	9	10	11	12	13	14
E	15	16	17	18	19	20	21	22
N	23	24	01	02	03	04	05	06

DA FORM 1 FEB 79 4678 EDITION OF 1 DEC 77 WILL BE USED UNTIL EXHAUSTED.
MEDCOM - 23165

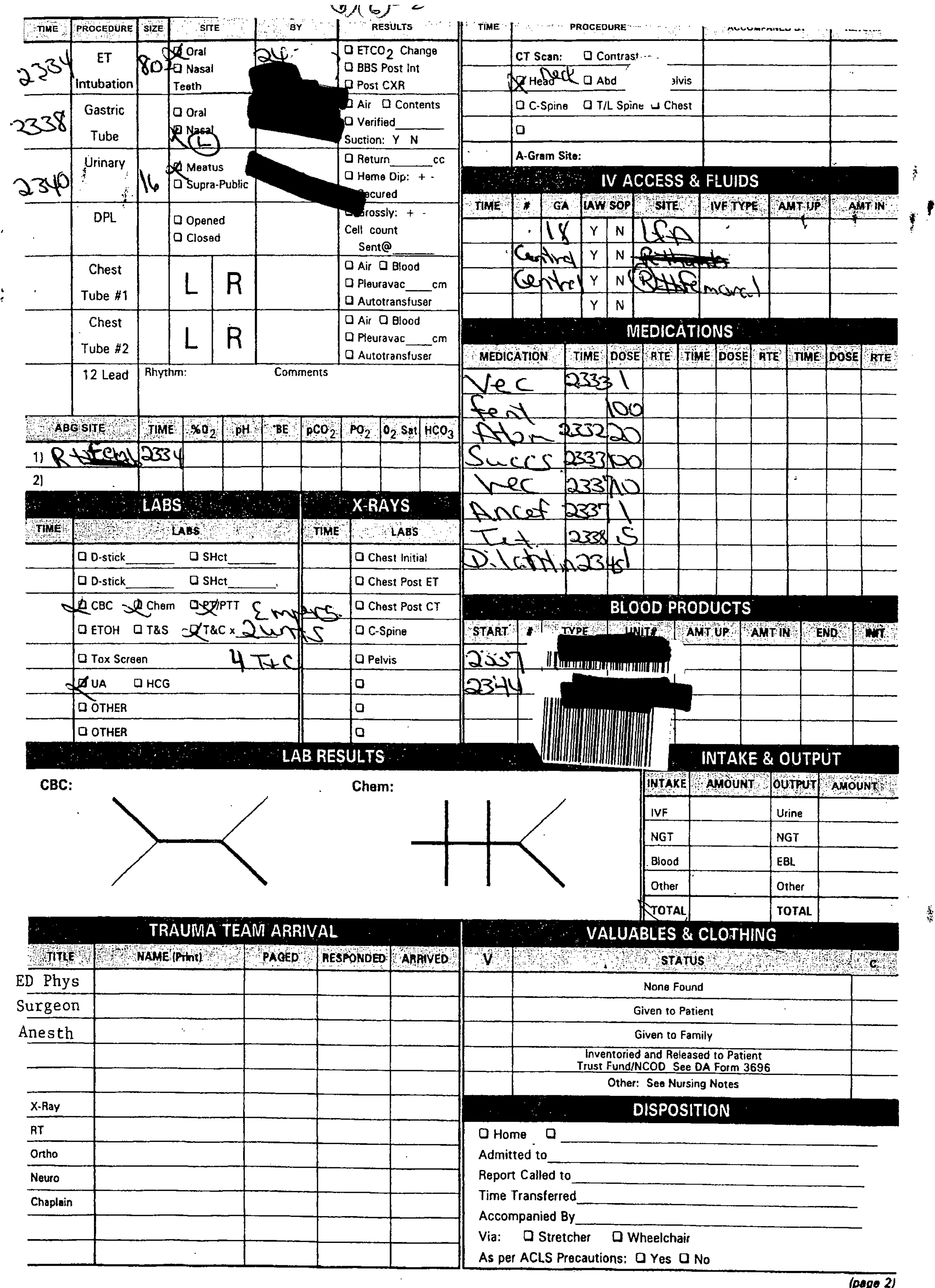
(b)(6)-2 all

Verify by Initialing		THERAPEUTIC DOCUMENTATION CARE PLAN (MEDICATIONS)				Mo. 11 Yr. 03
Order Date	Clerk/ Nurse	SINGLE ORDER, PRE-OPERATIVES	Date to be Given	Time to be Given	Time Given	Initials
10 NOV	[redacted]	D/C Dilantin	10 NOV 03	—	—	[redacted]
11 NOV	[redacted]	Tylenol 650 mg PO x1 now	11 NOV	—	—	[redacted]

Order/ Expir Date	Clerk/ Nurse	PRN MEDICATION, DOSE, FREQUENCY	INITIAL PROPER COLUMN FOLLOWING ADMINISTRATION TIME/DATE DISPENSED

*U.S. GPO: 1998-454-110/95216

MEDCOM - 23166



TIME	PROCEDURE	SIZE	SITE	BY	RESULTS
2334	ET Intubation	8.0	☒ Oral ☐ Nasal Teeth		☐ ETCO2 Change ☐ BBS Post Int ☐ Post CXR
2338	Gastric Tube		☐ Oral ☒ Nasal (L)		☐ Air ☐ Contents ☐ Verified Suction: Y N
2340	Urinary	16	☒ Meatus ☐ Supra-Public		☐ Return ___cc ☐ Heme Dip: + - Secured
	DPL		☐ Opened ☐ Closed		Grossly: + - Cell count Sent@
	Chest Tube #1		L R		☐ Air ☐ Blood ☐ Pleuravac ___cm ☐ Autotransfuser
	Chest Tube #2		L R		☐ Air ☐ Blood ☐ Pleuravac ___cm ☐ Autotransfuser
	12 Lead	Rhythm:		Comments	

ABG SITE	TIME	%O2	pH	BE	pCO2	PO2	O2 Sat	HCO3
1) R Fem	2334							
2)								

LABS

TIME	LABS
	☐ D-stick ___ ☐ SHct ___
	☐ D-stick ___ ☐ SHct ___
	☒ CBC ☒ Chem ☒ PT/PTT Emerg.
	☐ ETOH ☐ T&S ☒ T&C x 2 units
	☐ Tox Screen 4 T&C
	☒ UA ☐ HCG
	☐ OTHER
	☐ OTHER

X-RAYS

TIME	LABS
	☐ Chest Initial
	☐ Chest Post ET
	☐ Chest Post CT
	☐ C-Spine
	☐ Pelvis
	☐
	☐
	☐

LAB RESULTS

CBC:

Chem:

TIME	PROCEDURE	ACCOMPANIED BY
	CT Scan: ☐ Contrast	
	☒ Head Neck ☐ Abd Pelvis	
	☐ C-Spine ☐ T/L Spine ☐ Chest	
	☐	
	A-Gram Site:	

IV ACCESS & FLUIDS

TIME	#	GA	IAW	SOP	SITE	IVF TYPE	AMT UP	AMT IN
		18	Y	N	LFA			
	Central		Y	N	~~R Hand~~			
	Central		Y	N	R Femoral			
			Y	N				

MEDICATIONS

MEDICATION	TIME	DOSE	RTE	TIME	DOSE	RTE	TIME	DOSE	RTE
Vec	2333	1							
fent		100							
Ativan	2332	20							
Succs	2333	100							
Vec	2337	10							
Ancef	2337	1							
Tet	2338	.5							
Dilantin	2346	1							

BLOOD PRODUCTS

START	#	TYPE	UNIT#	AMT UP	AMT IN	END	INIT
2337							
2344							

INTAKE & OUTPUT

INTAKE	AMOUNT	OUTPUT	AMOUNT
IVF		Urine	
NGT		NGT	
Blood		EBL	
Other		Other	
TOTAL		TOTAL	

TRAUMA TEAM ARRIVAL

TITLE	NAME (Print)	PAGED	RESPONDED	ARRIVED
ED Phys				
Surgeon				
Anesth				
X-Ray				
RT				
Ortho				
Neuro				
Chaplain				

VALUABLES & CLOTHING

V	STATUS	C
	None Found	
	Given to Patient	
	Given to Family	
	Inventoried and Released to Patient Trust Fund/NCOD See DA Form 3696	
	Other: See Nursing Notes	

DISPOSITION

☐ Home ☐ ___

Admitted to ___

Report Called to ___

Time Transferred ___

Accompanied By ___

Via: ☐ Stretcher ☐ Wheelchair

As per ACLS Precautions: ☐ Yes ☐ No

(b)(6)-2 all

Rectal Temp:

TIME	BP	HR	RHY	RR		FIO2	MODE	E	V	M	T
2329	53/21	130		38							
2335	91/55	127		28							
man 2340	95/70										
2341	133/83	117		24							
2355	125/71	81		22	100						

GCS:

GLASGOW COMA SCALE

EYE OPENING	VERBAL RESPONSE	MOTOR RESPONSE
4 - Spon	5 - Oriented	6 - Obeys Commands
3 - To Voice	4 - Confused	5 - Localizes Pain
2 - To Pain	3 - Inapp Words	4 - Withdraws to Pain
1 - None	2 - Incomp Speech	3 - Flexion to Pain
	1 - None	2 - Extension to Pain
		1 - None

TIME	PROCEDURE	PERFORMED BY:
	☐ Backboard Removed	BY:
	☐ Downgraded	BY:

NOTES

Guaic - Neg.

* initially ACLS protocol followed. VS as noted, initial GCS 6, agonal Resp efforts, ↑ secretions therefore RSI protocol initiated, BS confirmed (B), ⊕ condensation in tube, Pt c̄ (R) fem line + PIV - Fluids running c̄ initial Hypotensive + thready pulse 2U O⊖ Blood given, BP/Pulse improved c̄ IVF + Blood NS on scene. See Below for Details

~20-30 yo

Pt is an Iraqi ♂ S/P GSW to (L) temporal area, arrived on litter c̄ head wrapped. initial VS noted, pupils 2mm sluggishly Reactive, Moved (R) LE; ∅ UE movements. eyes appeared to open x1 when evaluating head wound but ∅ spont thereafter, agonal Resp effort, HR 130's, Pt sedated + paralyzed for intubation. CT head c̄ localized fragments in (L) temporal region, ⊕ edema. NS present. (R) fem line placed. 2U O⊖ Blood given. Pt to OR for eval/removing fragments.

☆U.S.GOVERNMENT PRINTING OFFICE 1997-571-7000

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this for[illegible] AR 40-66; the proponent agency is the Office of The Surgeon [illegible]

REPORT TITLE: **TRAUMA [illegible]SHEET** — The proponent is Dept of Surgery

OTSG APPROVED (Date): QI Appr 11 Jun 97

EMS REPORT

TIME: ______ ETA: ______ UNIT: ______

MED COM: [X] Y [ ] N — 1 min.

ARRIVAL STATUS

TIME 2328 ☐ IV x ____ ☐ O_2 ____ 1/min ☒ C-Spine Immob

Meds: ☒ UKN ☐ None ☐ Yes: ______

Allergies: ☒ UKN ☐ None ☐ Yes: ______

Tetanus: ☒ UKN ☐ Current Last Meal/Fluid Intake ____ hrs

LMP: ______ ☐ ______

CRAC

PRIMARY SURVEY

AIRWAY

☒ Natural Patient [Y] [N]

☐ ETT ____ ☐ ____

☐ Secretions ____

BREATHING

☐ Labored ☐ Unlabored ☐ Absent

TRACHEA: ☐ Midline ☐ Deviated [L] [R]

CHEST SYMMETRY: [L] > = < [R]

CIRCULATION

PULSE: ☒ Present ☐ Absent

BLEEDING: [X] Y [N]

HEART TONES: ☒ Clear ☐ Muffled

SKIN: ☐ Warn ☐ Cool ☐ Hot

☐ Pink ☐ Pale ☐ Cyanotic ☐ ____

☐ Dry ☐ Moist ☐ Diaphoretic

SECONDARY SURVEY

DISABILITY

GCS: E 1

V 1

M 4

SPHINCTER TONE:

☐ WNL

☐ None

HEAD — Sluggish 2mm.

PUPILS: ☐ Equal ☐ Fixed ☒ React ☐ Dilated [L] [R]

TM: ☐ Clear ☐ Blood [L] [R]

NECK

C-Spine Tenderness: [X] Y [N]

Pain @ ______

JVD: [Y] [N]

HEART

RHYTHM: ☒ Regular ☐ ______

PULSES: ☐ Central ☐ Peripheral

LUNGS — Poor Resp Effort

BREATH SOUNDS: ☐ Bilat ☐ Equal ☐ Clear

Decreased [L] [R] Absent [L] [R]

Wheezes [L] [R] Crackles [L] [R]

ABDOMEN — Distended

☒ Soft ☐ Rigid ☐ Non-Tender

☐ Tender: ______

PELVIS

☐ Stable ☐ Unstable ☐ ____

Blood at meatus/vagina: [Y] [N]

Heme + ◯ Prostate: ☐ WNL ☐ Abnl

USE DIAGRAM TO DOCUMENT INJURIES AND PAIN

(AB)rasion
(AMP)utation
(AV)ulsion
Battle's Signs
(BL)eeding
(B)urn
(D)eformity
(E)cchymosis
(F)oreign Body
(H)ematoma
(LAC)eration
(P)uncture (W)ound
(Pain)
(S)eatbelt (S)ign
(S)tab (W)ound
(GSW) Gun Shot Wound

X GSW

VASCULAR ASSESSMENT

++ Strong | + Palpable | D Dopler

RN ______

PHYSICIAN [redacted] (b)(6)-2

(Continue on reverse)

PREPARED BY *(Signature & Title)* [redacted]

DEPARTMENT/SERVICE/CLINIC: ER

DATE: 11 Nov 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name--last, first, middle; grade; date; hospital or medical facility)*

EPW # [redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIAGNOSTIC STUDIES

☐ TREATMENT

ME[illegible]AL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form see, AR 40-66; the proponent agency is The Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)* QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	2 Nov 03 1830	INTILAS		INTILAS	2 Nov 03 0530	INTILAS [redacted] (b)(6)-2
NEURO	PUPILS	Pinpoint/brisk/Perrla				3mm Slow
	SENSORIUM	⊕ corneal reflex/grimaces				unresponsive to painful
		/ moves LUE ē painful				/ verbal stimuli, sedated
		stimuli. Ventriculostomy				on 10[8] propofol
		drain 20-30cc/hr ICP 9				
RESPIRATORY	RESPIRATION PATTERN	normal on SIMV 13				Even, unlabored
	BREATH SOUNDS	TV 700 Peep 5 FiO2 40%				Vent V_T 700 Peep 5 FiO_2 40%
	SECRETIONS	O2 sats 100% last				SpO_2 100 BPM 12
		ABG 1645 - O2 34[6]				Ø secretions
		Sx deferred @ this time				
		LCTA (B)				
SKIN	COLOR	AFR				AFR / gauze to head
	INTEGRITY	Intact x head				ē min serosanguinous fluid
IV SITE	LOCATION	(R) ac PIV / (R) femoral				(R) Femoral Cordis, (R)
	CONDITION	cordis / (R) radial				AC, (R) Radial A-line
		art line [illegible]				CDI, Ø s/s infection
		All lines patent				
		A-line reading &				
		waveform lapile.				
GASTRO	ABDOMEN	soft nondistended				soft, nondistended
	BOWEL SOUNDS	⊕ BS x 4 quadrants				hypo BS x 4 quads
		⊖ flatus ⊖ BM				NGT
GU	URINE	foley to gravity				FTG
	COLOR/CLARITY	yellow clear				Clear, light yellow
		adequate output / O				
CARDIOVASCULAR	CARDIACRHYTHM	Sinus tach 100-110s				Tachy ↓100's Ø ectopy
		Radial & pedal				+2 radial/pedal pulses
		pulses palpable				Ø edema noted <3sec
		+1				Cap refill

LEGEND

Cr - Creatinine
F_IO - Fraction of inspired O_2
F_IO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* SGT [redacted] (b)(6)-2

DEPARTMENT/SERVICE/CINC ICU 3

DATE 2 NOV 03

PATIENT'S INDICATIONS *(For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)*

#[redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART

☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER *(Specify)*

☐ DIGNOSTIC STUDIES

☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

MEDCOM - 23170

DATE 11/2/03 DX S/p GSW to head HOSPITAL DAY 1

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line				161/84	120/65	122/61	131/61	101/52		132/72	142/70	127/64	142/73	140/71	142/72	123/69	131/71	
BP Cuff					100/58	108/56	117/61	111/51		106/57		107/61						
Temperature				94.4	36.1	37.2	37.4	37.7				100.6						
Pulse				79	86	83	76	87		83	81	91	87	98	97	99	100	
Respiratory Rate				12	12	13	12	12		12	12	13	13	13	13	13	13	
SPO2				100	100	100	100	100		100	100	100	100	100	100	100	100	
FiO2				70	50	50	40	40		40		40		40		40		
MODE				SIMV	SIMV	SIMV	SIMV	SIMV		SIMV		SIMV		SIMV				
ICP				\	0	2	4	7		9	9	7	6	5	8	8	8	
CPP								72		72	80	75	86	87	81	81	82	
ART MAP/CPP								79		81	89	82	92	92	89	89	90	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
D5 0.9NS c̄ 20 mEq KCl				125	125	125	125	125	625	125	125	125	125	125	125	125	125	1000
NPB								100	100	100						200		300
Propofol				16.8	16.8	16.8	16.8	16.8	84	18	18	20	20	20	20	20	20	116
FFP				288	288				566									
TOTALS									1375 / 420									1916

OUTPUT

	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE HOUR/TOTAL					/280	90/370	70/440	80/	580	50/50	120/170	120/290	140/410	250/660	200/860	220/1080	180/1260	1260
URINE SP gr																		
URINE S/A																		
NG OUTPUT																		
NG PH																		
NG GUIAC																		
EMESIS																		
STOOL	#																	
DRAINS JP						15			15			30						50
DRAINS Ventric					30	18	15	5	68	5	∅	∅	∅					5
TOTALS									630									1315

ACLU-RDI 1675 p.132

DOD-036748

(b)(6)-2 all

POST-OP DAY

VITAL SIGNS	14	17	18	19	20	21	22	23
	101.1			101.0			101.2	
	97	105	104	101	110	10	112	105
	13	13	14	13	13	13	13	13
	100	100	100	100	100	100	100	100
	40	40	40	40	40	40	40	40
	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV	SIMV
	9	9	9	8	10	8	6	6
	90	92	82		80		90	
	99	101	91	90	90	87	84	81

INTAKE	14	17	18	19	20	21	22	23	8°T
	125	125	125	125	125	125	125	125	1000
							100	100	200
	20	20	20	23	25	25	25	27	186

OUTPUT

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	0530	0800	1645
MODE	SIMV	SIMV	SIMV
F_IO_2	45	45	40
TV	700	700	700
RATE	12	12	13
PEEP	5	5	5
ABG pH	7.433	7.417	7.492
PCO_2	35.2	38.7	31.5
pO_2	169	173	159
HCO_3	23	25	26
SAT	100	100	100
BASE	-1	Ø	3

LABORATORY DATA

TIME	0300	0420	0800	1645
GLUCOSE				
Na/K				
Cl/CO_2				
BUN/Cr				
WBC/PLATELET				
Hct/Hgb				
INR	1.52		1.49	

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATCH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN / SUCTION — TIME

24° I&O TOTALS

WT Yesterday ______ wt Today ______

INTAKE — IV ______ Po ______ TOTAL ______

OUTPUT — Urine: ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE | INITIALS

MEDCOM - 23[redacted]

NEUROLOGICAL ASSESSMENT

COMA SCALE			03	04	05	06	07	08	09	10	11	12	13	14	15	16	17	18	19	20	21	22	23	Z
EYES OPEN	SPONTANEOUSLY	4																						
	TO SPEECH	3																						
	TO PAIN	2																						
	NO EYE OPENING	1	1	1	1	1	1	1	1															
BEST VERAL RESPONSE	ORIENTED	5																						
	CONFUSED	4																						
	VERBALIZES	3																						
	VOCALIZES	2																						
	NO VOCALIZATION	1	T	T	T	T	T	T	T															
BEST MOTOR RESPONSE	OBEYS COMMANDS	6																						
	LOCALIZESPAIN	5																						
	FLEXION WITHDRAWAL	4																						
	ABNORMAL FLEXION	3																						
	EXTENSION TO PAIN	2																						
	NO RESPONSE	1	1	1	1	1	1	1	1															

LEGEND: C Closed by swelling; T Trach/Endo; S Slurring; D Dysphasia; R Receptive; E Expressive

LIMB MOVEMENT		03	04	05	06	07	08	09
ARMS	NORMAL POWER							
	MILD WEAKNESS							
	SEVERE WEAKNESS							
	ABNORMAL FLEXION							
	ABNORMAL EXTENSION							X
	NO RESPONSE	R/L	R/L	R/L	R/L	R/L	R/L	
LEGS	NORMAL POWER							
	MILD WEAKNESS							
	SEVEREWEAKNESS							
	ABNORMAL FLEXION							
	ABNORMAL EXTENSION							X
	NO RESPONSE	R/L	R/L	R/L	R/L	R/L	R/L	

R Right; L Left. Record Separately if there is a Difference between the tow sides

PUPILS		03	04	05	06	07	08	09
RIGHT	SIZE	3	3	3	3	2	2	2
	REACTION	+	+	+	+	++	++	++
LEFT	SIZE	3	3	3	3	2	2	2
	REACTION	+	+	+	+	+	+	[illegible]
PUPIL SCALE	● 2 ● 3 ● 4 ● 5 ● 6 ● 7 mm							
ICP						7	9	9
CEREBRAL PERFUSION PRESSURE (MAP-ICP)						72	72	80

++ Brisk; + Slow; − No Response; + Intact; − Abnormal

VASCULAR ASSESSMENT

HOURS	
	R L
	R L
	R L
	R L
	R L

++ Normal; + Weak; − Absent; D Doppler; R Right; L Left

POST-OP DAY

ACUITY LEVEL CLASSIFICATION

VITAL SIGNS

INTAKE

8° T

OUTPUT

RESPIRATORY DATA

	TIME	0430
	MODE	
	F_IO_2	
	TV	
	RATE	
	PEEP	
ABG	pH	7.463
	PCO_2	35.7
	pO_2	74
	HCO_3	26
	SAT	96
	BASE	2

LABORATORY DATA

TIME	
GLUCOSE	
Na/K	137/3.6
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	24/8

ACTIVITIES OF DAILY LIVING

TIME
MOUTH CARE
BATH
SKIN CARE
FOLEY CARE
TRACH CARE
ROM EXERCISES

TIME

TURN

SUCTION

24° I&O TOTALS

wt Yesterday ____ wt Today ____

INTAKE
IV ____
po ____
TOTAL ____

OUTPUT
Urine: ____
TOTAL ____

BALANCE ____

NURSE'S SIGNATURE | INITIALS

MEDCOM - 23174

(b)(6)-2 all

DATE 6 NOV 03 | DX GSW TO HEAD | HOSPITAL DAY

VITAL SIGNS																	
TIME	2400	0100	0200	0300	0400	0500	0600	0700	/	0800	0900	1000	1100	1200	1300	1400	1500
BP Arterial Line																	
BP Cuff	100/63	100/64	110/66	109/63	110/65	111/67	111/67	110/59		96/52	93/52	106/63	114/62				
Temperature	100.4		100.3			100		100.7		100.9	100.5	99.7	99.5				
Pulse	95	105	104	94	97	94	97	111		109	102	103	106				
Respiratory Rate	24	25	25	26	25	25	27	20		27	26	28	34				
O_2	100	100	100	100	100	100	100	100		100	100	100	100				
MODE	[redacted]																

INTAKE																		
TIME									8° T									8° T
IVF	125	125	125	125	125			125	750	125	125	100						350
IVPB Dil.	50					100			150									
IVPB Zosyn							50		50									
IVPB Zantac							50		50									
Juice PO							100		100									
Jello PO							50		50									
TOTALS									1150									350

OUTPUT																			
URINE	HOUR / TOTAL	200	160/360	140/500	120/620	240/860	175/1035	220/1255	200/1355		400	400/800	130/930						930
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS																			
TOTALS																			

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED *(Date)*
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

	TIME	0600	INITIALS		INITIALS		INITIALS
NEURO	PUPILS	OPENS SIMULTANEOUSLY					
	SENSORIUM	RESPONSIVE TO VERBAL					
		& PHYSICAL STIMULI.					
RESPIRATORY	RESPIRATORY PATTERN	SPONTANEOUS BREATHING					
	BREATH SOUNDS	CONGESTION LLL.					
	SECRETIONS	Ø					
SKIN	COLOR	PINK.					
	INTEGRITY	STAPLES IN SCALP INTACT.					
IV SITE	LOCATION	(R) FEMORAL LINE.					
	CONDITION	PATENT & WARM.					
GASTRO	ABDOMEN	NORMAL.					
	BOWEL SOUNDS	PRESENT - TOL PO					
		FLUIDS & CLEAR DIET.					
GU	URINE:	ADEQUATE / FOLEY					
	COLOR/CLARITY	CLEAR YELLOW.					
CARDIOVASCULAR	CARDIAC RHYTHM	S_1 S_2 PRESENT.					

LEGEND
Cr - Creatinine
F_iO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY *(Signature & Title)* (b)(6)-2 91WM6

DEPARTMENT/SERVICE/CLINIC: ICU 3

DATE: 6 Nov 03

PATIENT'S IDENTIFICATION *(For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)*

(b)(6)-4

- [ ] HISTORY/PHYSICAL
- [x] FLOW CHART
- [ ] OTHER EXAMINATION OR EVALUATION
- [ ] OTHER *(Specify)*
- [ ] DIAGNOSTIC STUDIES
- [ ] TREATMENT

DA FORM 1 MAY 78 4700
Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

MEDCOM - 23176

(b)(6)-2 all

POST-OP DAY

VITAL SIGNS	16	17	18	19	20	21	22	23	24
	91/53	100/62	107/64	115/56	105/60	92/59	114/60	101/53	
	101.1	98.4			99.6	100.1	100.1	100.1	
	107	100	105	107	98	103	94	97	
	27	25	25	28	24	24	25	27	
	98	100	100	99	98	100	99	91	
	67	78							

INTAKE	16	17	18	19	20	21	22	23	8° T
	125	125		125	125	125	125	125	750
			50				100	50	200
									950

OUTPUT	16	17	18	19	20	21	22	23	8° T
	300	240/540	300/840	220/1060	200/1260	160/1420	200/1620	150/1770	1770

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA	
TIME	0500
MODE	
F_iO_2	
TV	
RATE	
PEEP	
ABG pH	7.486
PCO_2	31.5
pO_2	81
HCO_3	24
SAT	97%
BASE	0

LABORATORY DATA	
TIME	
GLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING	
TIME	1300
MOUTH CARE	✓
BATH	✓
SKIN CARE	✓
FOLEY CARE	✓
TRACH CARE	
ROM EXERCISES	✓

TIME

TURN

SUCTION: 0800, 1000, 1115, 1230

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE: IV 2950; po ______; TOTAL ______

OUTPUT: Urine: 5000; TOTAL ______

BALANCE → 2050

NURSE'S SIGNATURE

MEDCOM - 23177

DATE | DX | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial Line																		
BP Cuff	97/60	90/49	94/51	97/57	100/60	95/53	103/52	124/40		96/54	104/58	108/55	98/51	105/54	100/53	98/53	100/51	
Temperature					100.4?							101.0	99.8					
Pulse	117	124	111	106	125	115	116	122		110	103	110	111	104	115	100	106	
Respiratory Rate	14	28	26	27	27	23	29	19		28	11	20	23	24	31	28	29	
SaO2	98%	97%	100%	100%	100%	99%	99%	99		99	99	100	99	99	99	100	100	
Mode	RA	RA	RA	RA	RA	RA	RA	RA		RA	RA	RA	RA	RA	RA	RA	RA	
MAP	77	64	67	77	75	68	71	67		69	74	78	65	75	70	69	68	

INTAKE

TIME	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
D5NS c 20 KCl	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
IVPB	50						200							50		150		
ORAl										250				250		[illegible]		
TOTALS																		

OUTPUT

	24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
URINE HOUR / TOTAL	100/100	180/280	150/430	120/550	180/730	200/930	150/1080	200/1280	1280	250/250	220/470	280/750	205/955	190/1145	210/1355	250/1605	340/1950	1950
URINE sp gr																		
URINE S/A																		
NG OUTPUT																		
NG pH																		
NG GUIAC																		
EMESIS																		
STOOL																		
DRAINS																		
TOTALS																		

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA
For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date)
QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME 0630	INITIALS	1900	INITIALS [redacted] (b)(6)-2		INITIALS
NEURO	PUPILS	Perrla 3mm brisk, pt able		PerrlA 3mm Brisk			
	SENSORIUM	to move all extremities,		(R) side weakness. Alert			
		(R) arm weaker than (L) arm, pt		+ oriented can follow			
		able to follow some commands.		commands & assists			
				w/ care			
RESPIRATORY	RESPIRATORY PATTERN	Reg, even, unlabored,		Reg even unlabored			
	BREATH SOUNDS	clear ~~to~~ c̄ diminished bases,		CTA c̄ diminished			
	SECRETIONS	thick white secretions,		bases pt able to			
		nebulizers tx q6°.		deep breath has cough			
				no secretions so far			
				Nebs Q 6°			
SKIN	COLOR	NFR., surgical incision (L) side		NFR. surgical incision			
	INTEGRITY	skull, staples, (L) Arm ecchy		(L) skull. (L) Arm			
		mosis.		ecchymosis.			
IV SITE	LOCATION	(R) Fem Cordis, (L) AC pheret		(R) Femoral cordis. D5			
	CONDITION	infusing; D5NS c̄ 20kcl		NS c̄ 20KCL. (L) AC			
		@125cc/hr		IV DC'D. no peripheral			
				access.			
GASTRO	ABDOMEN	Flat soft nontender, Hypo		Flat soft non tender			
	BOWEL SOUNDS	active x4 Ø, (+) flatus,		bowel sounds active			
		Clear liquid diet -		x4.			
				clear liquid diet 100%			
GU	URINE:	Foley ↓ gravity, clear		FTG light yellow			
	COLOR/CLARITY	yellow urine, Ø sediments		free from sediment			
		sufficient Amount ≥ 100's		adequate amounts.			
CARDIOVASCULAR	CARDIAC RHYTHM	S1 S2 Ø ectopy (+)2 pulses x		S1 S2 Ø ectopy.			
		4 ext, +2 (R) Arm (R) hand, (R) side		Sinus TACH. Ø symptoms			
		[illegible] +2 EDEMA.		Radials +2 Pedals +2			
				cap refill Brisk			
				edema R UE.			

LEGEND
Cr - Creatinine
F_IO_2 - Fraction of Inspired O_2
HCO_3 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - Pressure of Arterial CO_2
PEEP - Positive End Expiratory Pressure
S/A - Fractional
SAT - Saturation
TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) | DEPARTMENT/SERVICE/CLINIC | DATE

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

(b)(6)-2 all

POST-OP DAY

VITAL SIGNS

16	17	18	19	20	21	22	23	
93/55	93/55	112/54	106/67	93/47	110/62	93/46	102/60	
			101⁴	101			101³	
103	1?1	114	119	122	131	114	129	
33	25	30	30	30	28	29	27	
99	98	98	100%	98%	100%	100%	99%	

INTAKE

16	17	18	19	20	21	22	23	8° T
125	125	125	125	125	125	125	125	3000
						100	100	700
								700

OUTPUT

100	120/220	80/300	120/420	140/560	140/700	120/820	90/910

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	0400
MODE	NC
F_iO_2	2L
TV	
RATE	
PEEP	
ABG pH	7.41
PCO_2	39.2
pO_2	98
HCO_3	29
SAT	98
BASE	7

LABORATORY DATA

TIME	0430	1330
GLUCOSE	195	
Na/K	130/4.1	
Cl/CO_2	105/23	
BUN/Cr	6/.8	
WBC/PLATELET	7.8/129	
Hct/Hgb	19.9/6.2	23.5/?.5

ACTIVITIES OF DAILY LIVING

TIME	[redacted]
MOUTH CARE	1200
BATH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

	TIME	
TURN	1000	
	self	
	1500	
SUCTION	1000	1300
	1100	1700
	1200	
	1220	

24° I&O TOTALS

wt Yesterday ______ wt Today ______

INTAKE — IV ______ po ______

OUTPUT — Urine: ______

TOTAL ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE | INITIALS

[redacted]

DATE 05 Nov 03 | DX s/p gsw to head | PAGE 2 OF

HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15
BP Arterial Line																	
BP Cuff	99/48	93/45	102/57	91/47	94/42	93/47	97/48	94/47		90/50	95/42	107/56	84/42	90/60	100/53	110/64	102/54
Temperature			101.6		101.1			100.3						103.7		103.2	
Pulse	119	131	136	134	131	129	126	125		125	127	127	137	123	132	124	122
Respiratory Rate	22	29	28	26	25	28	28	29		30	25	25	29	26	33	21	32
SaO2	97%	100%	96%	99%	97%	97%	96%	95		100	100	98	99	100	97	100	100
mode	12 NC	12 NC	12 NC	12 NC	1 NC	RA	RA	12 NC		12 NC	12 NC	12 NC	12 NC	12 NC	12 NC	12 NC	12 NC
MAP	67	64	70	65	62	65	68			65	65	74					
ICP	4	4	10														
CPP	63	60	60														

INTAKE

TIME									8° T	08	09	10	11	12	13	14	15	8° T
D5 ½NS c 20 KCL	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
HVPB	50						150	100	300									
																200		
PRBC																200		200
												350	350					700
TOTALS									1500									2100

OUTPUT

		24	01	02	03	04	05	06	07	8° T	08	09	10	11	12	13	14	15	8° T
URINE	HOUR / TOTAL	90	70/160	120/280	110/390	100/490	110/600	140/740	120/840	~~1500~~ 840	120	152/272	140/412	120/532	150/600	170/72	110/850	102	1080
	sp gr																		
	S/A																		
NG	OUTPUT																		
	pH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	Ventric	5								5									
TOTALS										845									

MEDICAL RECORD—SUPPLEMENTAL MEDICAL DATA

For use of this form, see AR 40-66; the proponent agency is the Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8 Mar 89

INITIAL SHIFT ASSESSMENT

		TIME 0620	INITIALS [redacted] (b)(6)-2	TIME	INITIALS	TIME 1815	INITIALS [redacted] (b)(6)-2
NEURO	PUPILS					PERRL ®	
	SENSORIUM					Pt able to move all extremities, lifts ® ē assistance, pt moving around on bed	
RESPIRATORY	RESPIRATORY PATTERN					Reg, even, unlabored	
	BREATH SOUNDS					CTA ®	
	SECRETIONS					Thick white secretions coming from nasal trumpet. Thin white secretions from mouth	
SKIN	COLOR					NFR	
	INTEGRITY					Ⓛ sided skull incision, stapled	
IV SITE	LOCATION					Ⓡ Fem cordis, Ⓛ AC	
	CONDITION					~~Patent~~ cordis infusing D5 NS ē 20 KCL @ 12.5 cc/hr, Ⓛ AC heplocked, both s̄ s/s of inf x	
GASTRO	ABDOMEN					~~Flat~~ soft nontender	
	BOWEL SOUNDS					⊕ in all quads	
GU	URINE: COLOR/CLARITY					Foley to gravity yellow clear	
CARDIOVASCULAR	CARDIAC RHYTHM					ST ē S1 S2 noted, Ⓡ ectopy ® peripheral pulses x4 Ⓡ arm ē Ⓛ side of face & head swollen ē ⊕4 pitting edema to head	

(First column crossed out with diagonal line, marked "0800 ...")

LEGEND: Cr - Creatinine; F_iO_2 - Fraction of Inspired O_2; HCO_3 - Bicarbonate; ICP - Intracranial Pressure; PCO_2 - Pressure of Arterial CO_2; PEEP - Positive End Expiratory Pressure; S/A - Fractional; SAT - Saturation; TRACH - Tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) (b)(6)-2 [redacted] LPN

DEPARTMENT/SERVICE/CLINIC ICU 3

DATE 5 Nov 03

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility)

#EPW [redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIAGNOSTIC STUDIES
☐ TREATMENT

DA FORM 4700, 1 MAY 78
Proponent: Dept of Nurs

MEDDAC FBg OP 375, 1 Apr 90 (HSXC-NU)

MEDCOM - 23182

POST-OP DAY

VITAL SIGNS

	16	17	18	19	20	21	22	23
cuff	95/41	101/52	91/53	91/55	98/49	91/54	94/48	95/48
(T)	101.5					100.0		101.8
pulse	135	156	131	127	128	125	129	130
RR	29	34	26	26	27	29	27	16
SpO2	95	92	99	100%	100%	97%	99%	99%
mode FiO2	40/PM	RA	4L NC	4L NC	4L NC	2L NC	2L NC	2L NC
MAP	63	71	47	69	68	64	67	66
ICP	10	6	6	5	8	5	11	9
CPP	53	65	41	64	60	59	56	57

INTAKE

	16	17	18	19	20	21	22	23	8°T
IVF	125	125	125	125	125	125	125	125	
IVPB			50				100	100	

OUTPUT

	PO	140/240	120/380	120/500	110/610	110/720	70/790	70/860	86
			300						
		50	30		40	10	20		

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

TIME	0400	1300	1600
MODE	SIMV	PM	PM
F_iO_2	40	40	40
TV	700		
RATE	11		
PEEP	5		
ABG pH	7.33	7.503	7.534
PCO_2	37.3	29.4	29.3
pO_2	83	95	211
HCO_3	20	23	25
SAT	96	98	100
BASE	-6	Ø	2

LABORATORY DATA

TIME	430
GLUCOSE	115
Na/K	130/3.4
Cl/CO_2	104/22
BUN/Cr	5/1.1
WBC/PLATELET	9.3/103
Hct/Hgb	23.9/7.4
Calc ICa	1.18

ACTIVITIES OF DAILY LIVING

TIME			
MOUTH CARE			
BATCH			
SKIN CARE			
FOLEY CARE			
TRACH CARE			
ROM EXERCISES			

TURN / SUCTION

TIME

SUCTION
0600
0830
1300

24° I&O TOTALS

WT Yesterday ______ wt Today ______

INTAKE: IV ______ Po ______ TOTAL ______

OUTPUT: Urine: ______ ______ TOTAL ______

BALANCE ______

NURSE'S SIGNATURE | INITIALS

[redacted] (b)(6)-2

DATE 4 NOV 03 | DX GSW HEAD | HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	102/52	95/57	99/56	102/58	101/54	100/57	103/57	105/40		101/55	99/37	101/53	106/40	94/57	98/54	94/55	100/58	
Temperature	101.9	101.5	101.4	100.9	100.6		100.6	100.9					100.7					
Pulse	116	111	110	111	109	112	113	112		109	113	123	120	156	139	132	131	
Respiratory Rate	11	11	11	11	11	11	11	11		11	11	15	16	24	21	23	26	
SPO2	100	100	100	100	100	100	100	100		100	100	100	100	100	97	96	97	
mode/FiO2	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40						Trach	FM/40	FM/40	FM/40	
MAP	69	67	73	73	71	69		75		74	73	72	78	76	72	74	74	
ICP	13	11	12	11	11	11	11	13		12	12	7	10	10	10	8	13	
CPP	56	56	61	62	60	58		62		62	61	65	(68)	66	62	62	61	

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1200
IVPB	50						100	150	300							200		200
Propofol	12.6	10.5	10.5	10.5	10.5	10.5	10.5	8	83	8	7	7	off	off	—	—	—	22
fentanyl	12.5	12.5	12.5	12.5	12.5	12.5	10	10	95	10	8	8	off	off	—	—	—	26
TOTALS									1678									1948

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR/TOTAL	110/	60/170	38/208	40/248	50/298	40/338	35/373	30	425	70	100/170	50/220	60/280	100/380	120/500	140/640	200	840
	SP gr																		
	S/A																		
NG	OUTPUT							150		150					50				50
	PH									5.5									
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	Ventric	45	8	4	14	4	4		∅	85		5				5		20	30
TOTALS										660									890

(b)(6)-2 except very bottom

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA
For use of this form see, AR 40-66; the proponent agency is The Office of The Surgeon General

REPORT TITLE
INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

		TIME	INTILAS		INTILAS	1815	INTILAS
NEURO	PUPILS					PERRL (B) 3mm brisk	
	SENSORIUM					Pt ē purposeful movement in all extremities except (R) UE, doesn't follow commands	
RESPIRATORY	RESPIRATION PATTERN					Reg, even, unlabored	
	BREATH SOUNDS					CTA (B)	
	SECRETIONS					Coughs up white sputum	
SKIN	COLOR					NFR	
	INTEGRITY					(L) side skull incision, stapled	
IV SITE	LOCATION					(R) fem cordis ē (L) AC PIV	
	CONDITION					Patent s̄ s/s of infx infusing D5½NS ē 20 KCL @ 125 cc/hr. PIV heplocked	
GASTRO	ABDOMEN					Flat soft nontender	
	BOWEL SOUNDS					Hypoactive X 4	
GU	URINE					Foley to gravity	
	COLOR/CLARITY					Yellow clear	
CARDIOVASCULAR	CARDIACRHYTHM					ST ē S1S2 noted, no ectopy	

(Diagonal handwritten note across first column: "See Notes")

LEGEND
Cr - Creatinine
F_iO - Fraction of inspired O_2
F_iO_2 - Bicarbonate
ICP - Intracranial Pressure
PCO_2 - PRESSURE OF ARTRIAL CO_2
PEEP - Positive end Expiratory Pressure
S/A - Fractional
SAI - Saturation
TRACH - Iracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] LPN

DEPARTMENT/SERVICE/CINC ICU 3

DATE 4 Nov 03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW [redacted] (b)(6)-4

☐ HISTORY/PHYSICAL ☐ FLOW CHART
☐ OTHER EXAMINATION OR EVALUATION ☐ OTHER (Specify)
☐ DIGNOSTIC STUDIES
☐ TRETMENT

DA FORM 4700, 1 MAY78
Proponent Dept of Nurs

MEDCOM - 23185

WAMC OP 375 (Redesignated)
1 APR 90 (HSXC - NU)

POST-OP DAY

VITAL SIGNS

14	17	18	19	20	21	22	23	
129/61	120/69	119/70	126/68	93/47	91/53	106/51	102/59	
	99.2		100			103.5	103.3	
93	107	103	130	121	124	140	122	
11	11	11	13	10	17	22	11	
100	100	100	100	100	100	100	100	
SIMV 40	SIMV 40	SIMV 40	Simv 40	Simv 40	SIMV 40	Simv 40	Simv 40	
87	91	88	88	67	70	72	77	
10	11	9	11	10	9	13	13	
77	80	79	77	57	61	59	64	

INTAKE

14	17	18	19	20	21	22	23	8°T
125	125	125	125	125	125	125	125	1000
						100	100	200
8	8	8	12.6	12.6	8.4	12.6	12.6	70.2
5	7.5	7.5	10	10	10	12.5	12.5	75
							1345.2	

OUTPUT

14	17	18	19	20	21	22	23	
100	115/215	60/275	120/395	70/465	70/535	120/655	120/775	775
		150						160
5	15	20	50	17	18	11	10	146
								1071

ACUITY LEVEL CLASSIFICATION

RESPIRATORY DATA

		0400	0515
TIME		0400	0515
MODE		SIMV	SIMV
F_iO_2		40	40
TV		700	700
RATE		13	11
PEEP		5	5
ABG	pH	7.56	7.42
	PCO_2	27.1	31.4
	pO_2	152	135
	HCO_3	24	21
	SAT	100	99
	BASE	2	-4

LABORATORY DATA

TIME	
CLUCOSE	
Na/K	
Cl/CO_2	
BUN/Cr	
WBC/PLATELET	
Hct/Hgb	

ACTIVITIES OF DAILY LIVING

TIME	
MOUTH CARE	
BATCH	
SKIN CARE	
FOLEY CARE	
TRACH CARE	
ROM EXERCISES	

TURN / SUCTION — TIME

24 °180 TOTALS

WT Yesterday ______ wt Today ______

INTAKE	OUTPUT
IV 4115.2	Urine: 2866.5
Po ______	______
TOTAL ______	TOTAL ______

BALANCE 1248.7

NURSE'S SIGNATURE | INITIALS

[redacted] (b)(6)-2

DATE	DX	HOSPITAL DAY

VITAL SIGNS

TIME	24	01	02	03	04	05	06	07		08	09	10	11	12	13	14	15	
BP Arterial line																		
BP Cuff	109/64	105/65	112/69	112/66	111/77	116/73	120/70	118/66		114/63	117/67	129/74	125/69	126/70	122/68	127/71	124/51	
Temperature		100.2			[illegible]		100.9			99.9					99.6			
Pulse	112	104	100	117	106	110	100	100		97	98	114	104	95	90	110	111	
Respiratory Rate	13	13	13	13	11	11	11	16		11	11	11	11	11	11	11	12	
O2 sats	100	100	100	100	100	100	100	100		100	100	100	100	100	100	100	100	
mode/FiO2	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40		SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	SIMV 40	
MAP	83	80	83	87	93	89	91	85		82	81	98	89	91	90	91	79	
ICP	5	9	9	10	12	11	5	10		8	10	11	9	9	11	9	12	
CPP	78	71	74	77	81	78	89	75		74	71	87	80	82	79	82	67	

MAP
-ICP

INTAKE

TIME	24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
IVF	125	125	125	125	125	125	125	125	1000	125	125	125	125	125	125	125	125	1000
IVPB						100	100		200							200		200
Propofol	21	21	21	21	21	21	21	21	168	21	21	16	16	12	12	12	12	122
fentanyl	5	5	5	5	5	5	5	5	40	5	5	5	5	5	5	5	5	40
TOTALS									1408									1362

OUTPUT

		24	01	02	03	04	05	06	07	8°T	08	09	10	11	12	13	14	15	8°T
URINE	HOUR / TOTAL	60	140/200	80/280	80/360	50/410	45/455	50/505	70	575	35	60/95	70/165	75/240	60/300	90/390	80/470	115/585	585
	SP gr																		
	S/A																		
NG	OUTPUT	→					300			300									
	PH																		
	GUIAC																		
EMESIS																			
STOOL																			
DRAINS	Ventric	35	3	0	15	5	45	30	18	133	15	10	50	15	15	2.5	40	25	172.5
	JP	→						30		30									
TOTALS										1038									757.5

(b)(6)-2 all except very bottom

MEDICAL RECORD-SUPPLEMENTAL MEDICAL DATA

For use of this form see, AR 40-66; the proponent agency is The Office of The Surgeon General

REPORT TITLE

INTENSIVE CARE NURSING FLOW SHEET

OTSG APPROVED (Date) QA Appr 8Mar 89

INITIAL SHIFT ASSESSMENT

Section	Item	TIME 0630 INTILAS [redacted]	INTILAS	1830 INTILAS [redacted]
NEURO	PUPLIS	3mm PERRL Brisk		3mm Brisk PERRL
	SENSORIUM	responsive to pain stimuli flex (L) arm and (L) leg propofol @ 30mcg/kg/hr		Sedated on 75mcg Fentanyl & 30mcg propofol. Moves (L) arm and leg. responds to pain stimuli
RESPIRATORY	RESPIRATION PATTERN	Vent SIMV 11 TV 700		Even, unlabored
	BREATH SOUNDS	FiO2 40% PEEP 5 lungs		Vent. ETT 28 @ teeth
	SECRETIONS	CTA. suctioned small secretions		Vt 700 Peep 5 FiO2 40% BPM 11, SPO2 100%
SKIN	COLOR	NFR		NFR
	INTEGRITY	(L) side head c sutures draining serous sanguinous fluid small amount.		GSW to head, Kerlix @ head Ventriculostomy (L) drainage or
IV SITE	LOCATION	(R) AC PIV; (R) femoral cordis. Patent. Ø signs infection.		(L) Radial A-line (R) AC, (R) Femoral Cordis / all are
	CONDITION			CDI, Ø S/S infection
GASTRO	ABDOMEN	Soft nondistended		Soft, nondistended
	BOWEL SOUNDS	+BS x4. Ø BM		ØBM ⊕BS x4 quads
GU	URINE	Foley to gravity		FTG
	COLOR/CLARITY	Clear yellow urine adequate amount		Clear dark yellow urine
CARDIOVASCULAR	CARDIACRHYTHM	S1-S2 Ø ectopy STach to PSR. +2 peripheral pulses x4 capfill ≤3sec.		S1S2 Ø ectopy Tachy in ↑110's to 120's. +2 radial/pedal pulses

LEGEND
- Cr - Creatinine
- F_IO - Fraction of inspired O_2
- F_IO_2 - Bicarbonate
- ICP - Intracranial Pressure
- PCO_2 - PRESSURE OF ARTRIAL CO_2
- PEEP - Positive end Expiratory Pressure
- S/A - Fractional
- SAI - Saturation
- TRACH - tracheostomy

(Continue on reverse)

PREPARED BY (Signature & Title) [redacted] /AW

DEPARTMENT/SERVICE/CINC ICU 3

DATE 3 Nov 03

PATIENT'S INDICATIONS (For typed or written entries give: Name—Last, First, middle; grade; date; hospital or medical facility)

EPW [redacted] (b)(6)-4

- ☐ HISTORY/PHYSICAL
- ☐ FLOW CHART
- ☐ OTHER EXAMINATION OR EVALUATION
- ☐ OTHER (Specify)
- ☐ DIGNOSTIC STUDIES
- ☐ TRETMENT

DA FORM 1 MAY78 4700
Proponent Dept of Nurs

MEDCOM - 23188

WAMC OP 375 (Redesignated) 1 APR 90 (HSXC - NU)

(b)(6)-2 unless marked otherwise

1. Reporting MTF	2. MTF Locat IZ	Admission and Coding Information For use of this form, see AR 40-400; the proponent agency is OTSG	
3. Register Number (b)(6)-4	Name (Last, First, MI) (b)(6)-4	4. Pay Grade FGN	5. Sex M

6. DoB (YYYYMMDD)	7. Age at Admission 42Y	8. Race Z	9. Ethnicity 9	Religion
10. Length of Service	ETS	11. FMP ~~09~~ 20	12. Social Security Number (b)(6)-4	

Organization (Active Duty Only)	13. Marital Status	Hour of Admission 23:37	Branch / Corps: ARMY

14. Flying Status NO	15. Beneficiary Category K78-PRISONER OF WAR/INTERNEES	16. Zip Code of Residence:

17. Unit Location	18. MOS	19. Trauma BC	Prev. Admission NO

20. Source of Admission Direct from ER	Ward: ICU3	Name / Relationship of Emergency Addressee Address of Emergency Addressee
Name and Location of Medical Treatment Facility: (b)(2)-2		Telephone Number of Emergency Addressee
21. Type of Disposition TRF-OTH	22. MTF Transferred To	23. Date of Disposition (YYYYMMDD) 2003-11-15
24. Clinic Svc - Admitting ABD - NEUROSURGERY	25. MTF Transferred From	26. Date this Admission (YYYYMMDD) 2003-11-01
27. Location of Occurrence	28. MTF of Initial Admission	29. Date of Initial Admission 2003-11-01

FOR LOCAL USE

Type Patient (Inpatient / Outpatient): Inpatient

Admission Diagnosis Narrative: GSW HEAD

Procedure Narrative(s):

Cause of Injury Narrative:

A	Signature of Admitting O

Automated Facsimile - DA FORM 2985, MAR 2000 MEDCOM - 23189

(b)(6)-

SI #[redacted]

(b)(6)-2 all unless indicated otherwise

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

YELLOW FIELDS MUST BE FILLED IN, IF APPLICABLE, UPON APPREHENSION

[ ] Offense against Civilian(s) [check one] If "Other" then describe:

[ ] Arson (I.P.C. 342)	[ ] Burglary or Housebreaking (I.P.C. 428)
[ ] Solicitation of Fornication/Prostitution (I.P.C. 399)	[ ] Extortion/Communicating Threats (I.P.C. 430)
[ ] Rape/Indecent/Sexual Assaults/Acts (I.P.C. 393-98, 402)	[ ] Theft (I.P.C. 439)
[ ] Murder (I.P.C. 405)	[ ] Destruction of Property (I.P.C. 477)
[ ] Aggravated Assault/Assault With Intent To Kill (I.P.C. 410)	[ ] Obstructing a Public Highway/Place (I.P.C. 487)
[ ] Maiming (I.P.C. 412)	[ ] Discharging Firearm/ Explosive in City/Town/Village (I.P.C. 495)
[ ] Simple Assault (I.P.C. 415)	[ ] Riot or Breach of Peace (I.P.C. 495(3))
[ ] Kidnapping (I.P.C. 421)	[ ] Other

[X] Offense against Coalition Forces [check one] If "Other" then describe:

[ ] Violation of Curfew	[ ] Trespass on Military Installation or Facility
[ ] Illegal Possession of Weapon	[ ] Photographing/Surveilling Military Installation or Facility
[ ] Assault/Attack on Coalition Forces	[ ] Obstructing Performance of Military Mission
[ ] Theft of Coalition Force Property	[ ] Other

Apprehending Unit: 4th INF DIV DIV ARTY | Location Grid: [redacted]

Date of Incident: (D/M/Y) 01/11/03 to / / | Time of Incident: hrs to hrs | Date of Report: (D/M/Y) 2/11/03 | Time of Report: [redacted] 2327 0650 hrs

Detainee	Key Connected Person: [ ] Victim [ ] Witness
Detainee #: [redacted] (b)(6)-4	
Last Name: [redacted] (b)(6)-4	Last Name:
First Name: [redacted] Given Name: [redacted]	First Name: Given Name:
Hair Color: BN; Scars/Tattoos/Deformities:	Hair Color: ; Scars/Tattoos/Deformities:
Eye-Color: BN; Weight: lb; Height: in	Eye-Color: ; Weight: lb; Height: in
Address:	Address:
Place of Birth:	Place of Birth:
Ethn/Tribe/Sect: ; Sex: [X] M [ ] F; Phone#: ; DOB D/M/Y: ; [ ] Mobile [ ] Regular	Ethn/Tribe/Sect: ; Sex: [ ] M [ ] F; Phone#: ; DOB D/M/Y: ; [ ] Mobile [ ] Regular
[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:	[ ] Passport [ ] Dr. license [ ] Other (specify) Document #:

Total Number of Persons Involved ____ (list names/identifying info on reverse under "Additional Helpful Information")

[ ] Vehicle Information Vehicle Number ____ of ____ Vehicle(s) Owner:

Make:	Color:	VIN:	
Model:	Type:	Plate No.:	Number of People in Vehicle:
Year:	Names of People in Vehicle:		
Contraband/Weapons in Vehicle:			

[ ] Property/Contraband [ ] Weapon | Photo Taken of Suspect with Weapon/Contraband. Yes/ No

Type:		Model:	Color/Caliber:
Serial No:	Quantity:	Make:	Receipt Provided to Owner: Yes/ No
Other Details:		Where Found:	Owner:

Name of Assisting Interpreter: | Email, Phone, or Contact Info.

Detaining Soldier's Name (Print): [redacted] Last, First MI	Supervising Officer's Name (Print): CPT [redacted] Last, First MI
Signature: [redacted]	Signature:
Email:	Email: [redacted]
Unit Phone: Date: / /	Unit Phone: [redacted] Date: / /

MEDCOM - 23190

(b)(6)-2 unless otherwise indicated

COALITION PROVISIONAL AUTHORITY FORCES APPREHENSION FORM

Why was this person detained? At Flash Check point in a station wagon he turned away from check point, CP fired a warning shot. Kept going, fired again, he was shot. Car flipped. He fell out.

Who witnessed this person being detained or the reason for detention? Give names, contact numbers, addresses.
CPT [redacted]
Night Battle CAPTAIN
4th INF DIV DIV ARTILLERY
[redacted]

How was this person traveling (car, bus, on foot)? Car Station wagon

Who was with this person?

What weapons was this person carrying? IED material

What contraband was this person carrying?

What other weapons were seized?

What other information did you get from this person?

Additional Helpful Information: Sustained GSW to head, info obtained via phone call @ 01:45 JNCC C3 by Sgt [redacted] JNCC PAD
[redacted] (b)(2)-2

MEDCOM - 23191

(b)(6)-2 all unless otherwise indicated

Automated Facsimile

INPATIENT TREATMENT RECORD COVER SHEET

For use of this form, see AR 40-400, the proponent agency is OTSG

1. Register Nbr	2. Name (b)(6)-4	3. Grade FGN	Admission Remarks
[redacted] (b)(6)-4	[redacted]		

4. Sex	5. Age	6. Race	7. Religion	8. LnthOfSvc	9. ETS	10. PrevAdm
M		X				NO

11. FMP	12. SSN	13. Organization	14. Ward
99	[redacted] (b)(6)-4		ICU1

15. FlyStatus	17. Dept / Ben	18. BranchCorps	19. UIC / ZIP	20. Type Case
	K78-PRISONER OF WAR/INTER			DIS

21. Source of Admission	22. Hour Of Adm:	23. Clinic Service
Direct from ER	09:38	ABA - GENERAL SURGERY

24. Name/Relation of Emergency Addressee	25. Type Disp	26. Date of Disp
	TRF-OTH	2003-12-09

27a. Address of Emergency Addressee	27b. Telephone No	28. Date This Adm:	AdmittingOfficer:
		2003-11-03	ELLISON

29. ReportingMTF	30. Date Init Adm	32. Units Blood Components
[redacted] (b)(2)-2	2003-11-03	

31. Selected Administrative Data

Marital Status: DoB:

In/Out Patient: Inpatient MOS:

33. Cause Of Injury:

34. Diagnosis / Operations and Special Procedures:

GSW ABD/SCRTUM/GROIN

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	7	7

35. Total Days This Facility

Absent Sick Days	Other Days	ConLv / Coop Care Days	Supplemental Care	Bed Days	Total Sick Days
0	0	0	0	7	7

Signature of Attending Medical Officer	Signature of PAD or Medical Records Officer
[redacted]	[redacted]

MEDCOM - 23192

Automated Facsimile DA FORM 364[redacted]

ACLU-RDI 1675 p.153

DOD-036769

MEDICAL RECORD	ABBREVIATED MEDICAL RECORD

PERTINENT HISTORY, CHIEF COMPLAINT, AND CONDITION ON ADMISSION (Enter date of admission)

24 year old Iraqi male with a GSW to the Abdomen + right groin 12 hours ago. Arrived with no prior tx (other than dressings) States he is otherwise healthy

PHYSICAL EXAMINATION HR 65 BP = 112/51 Sat% = 100%

Awake + alert Lungs Clear
Small (L) flank wound and large anterior abdominal wound
Destruction of the scrotum with dark color testicle
Large right groin wound c excellent distal pulses
Moves all extremities

PROGRESS (Enter date of discharge and final diagnosis)

A = GSW to Abd / Groin + Scrotum
Plan = Ex lap, (R) groin exploration + scrotal debridement

(b)(6)-2

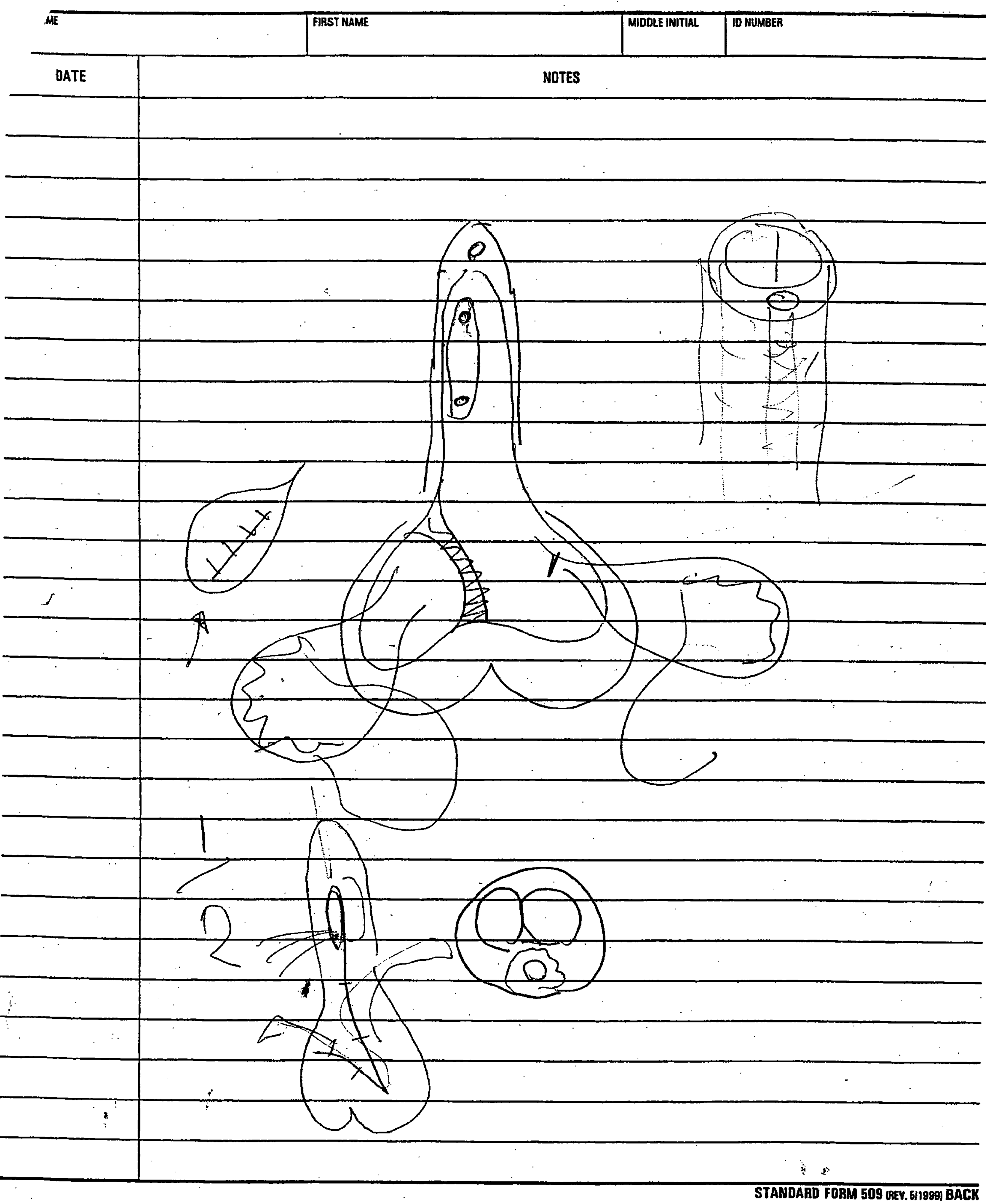
SIGNATURE [redacted] | DATE 3 NOV 03 | IDENTIFICATION NO. | ORGANIZATION

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; grade; date; hospital or medical facility) | REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

CO

ABBREVIATED MEDICAL RECORD
Standard Form 539
GENERAL SERVICES ADMINISTRATION AND INTERAGENCY COMMITTEE ON MEDICAL RECORDS
FIRMR (41 CFR) 201-45.505
OCTOBER 1975
539-106



NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES

STANDARD FORM 509 (REV. 5/1999) BACK

USAPA V1.00

MEDCOM - 23194

ACLU-RDI 1675 p.155

DOD-036771

(b)(6)-2 except very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
03 NOV03	pt recieved From OR @ 1420 pt VS- BP 128/69 T-94.9 HR-102 RR-16
@ 1450	SpO2 - 100% on 8L via Facemask. Pt completing 1 unit of blood that was started in
	OR pt shows no sign or Negative reaction pt given 6100cc of crystaloids c̄ 800
	output during procedure current vital signs - BP 121/55 T-96.8 HR-114 RR-16
	SpO2 100% on 12L non rebreather no signs of acute distress noted @ present will
	continue to monitor ——— [redacted]
@ 1530	pt assessment complete see Flowsheet for details pt doing well @ present
	pt remains sleeping from procedure will continue to monitor pt VS. for
	Δ's no signs of acute distress noted @ present will continue to monitor
	——— [redacted]
@ 1730	pt VSS no problems @ present O2 wean to RA c̄ Sats of 96% pt unable
	to take 1800 valium pt still drowsy from OR. Meds nasal trumpet remains
	in place pt ARMS Ⓡ & Ⓛ LEGS Ⓡ cleaned of blood & mud pt shows no
	signs of acute distress @ present will continue to monitor [redacted] PFC
@ 1830	Report recieved from PFC [redacted]. Pt VSS, still
	sedated from OR today. ——— [redacted]
@ 2030	Dressing to Ⓡ IJ Δ'd ——— [redacted]
@ 2040	A-line pulled while Δ'ing dressing. [redacted]
@ 2100	Received report from SPC [redacted]. VSS, Pt hard
	to wake, will continue to monitor. [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
4NOV03	Pt resting comfortably in bed, VSS. Will continue
0030	to monitor. [redacted]
0100	Pt SATs ↓ to 88%. Placed pt on O2 15L NR, SATs
	↑ to 100%. Will continue to monitor. [redacted]
04NOV03 @0605	pt report recieved @ 0600 VSS pt shows no signs/symptoms of acute distress @ present
	will continue to monitor [redacted]
@0610	pt valium held pt unable to tolerate @ this time will monitor for S/s of pain to determine
	if pain medication needed [redacted]
@0800	pt dressings Δd c̄ no complication pt tolerated well pt Temp @ 0600 101.3 tylenol
	given pt ↓ temp to 100.5 will continue to monitor [redacted]
@1025	pt being weaned from O2 slowly Sat continue to drop s̄ O2 pt temp
	↑100.7 will continue to monitor for Δ's [redacted]
@1710	pt temp remains in low 100's pt SPO2 in mid 90's c̄ RA pt vital stable
	pt doing well @ this time will continue to monitor [redacted]
@1755	pt using I.S. often pt on RA will continue to monitor [redacted]
@1810	Report recieved from PFC [redacted] pt VSS, temp
	100.6. TLC to (R) IJ, all ports flush well. Supra pubic
	catheter draining clear yellow urine. [redacted]
@2200	pt VSS, temp 100.5. IS use encouraged. [redacted]
@2330	Drsg Δ done to scrotum & (R) groin wound. Wet
	to dry drsgs to both sites. [redacted]
@2400	Valium @ 2400 held BP 104/41 [redacted]
@0200	pt VSS Temp 100.1 [redacted]
@0600	Report given to Sgt [redacted] [redacted]

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

MEDCOM - 23196

ACLU-RDI 1675 p.157

DOD-036773

(b)(6)-2

LAST NAME	FIRST NAME	INITIAL	ID NUMBER

DATE	NOTES
05NOV03 0914	All Drsg. Δ completed @ this time. 25mg Fentanyl IVP given via Major [redacted]. IS done after drsg Δ able to hold all 3 balls up x10. ⊖ Respiratory distress noted. Will continue to monitor. Sgt [redacted]
0945	Percocet Tab # po given for pain. Will continue to monitor. Sgt [redacted]
5NOV03 0945 8.9/159 27.9 137/104/29/89 3.6/27	Surgery HD#3 ICU D#3 POD#2 Levaquin/Unasyn D#3 Pt. did well over night. Has developed some nasal congestion. Dressings Δ'ed + wounds look good. Will continue dressing Δ's. Penis dressing Δ'ed by Dr. [redacted] (Urology) today. Abd is slightly distended ↑ hypoactive BS. Will continue to follow and slowly give p.o. [redacted]
1030	Pt. resting in bed c̄ eyes closed. ⊖ distress noted. Will continue to monitor. Sgt [redacted]
1221	Consumed 85% of lunch - soft diet. ⊖ complications noted @ present time. Will continue to monitor for any S/Sx of complications. Sgt [redacted]
1427	.5L O2 per NC per Sat. ↓89%. SpO2 91% @ present time. Will continue to monitor. Sgt [redacted]
1500	↑ O2 to 1L per NC SpO2 94%. Will monitor. [redacted]

STANDARD FOR[redacted]

USAPA V1.00

(b)(6)-2 except for very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
05NOV03	IVF Δ'ed to NS KCL 20 MEQ/Liter @ 100cc/hr.
1640	SpO2 95% @ 2L per NC.
1748	Ø distress noted @ present time. Ø voice of
	complaint of pain @ this time. Will continue
	to monitor.
1800	Received report from day shift. Pt appears to
	be resting comfortably in bed. VSS. Ⓡ side ES c̄
	NS @ 100cc/hr. Foley draining to gravity, clear
	yellow urine. Pt on 1L O2 NC to maintain SATs @
	100% (>95%). Dressing to abd and penis C/D/I. Will
	continue to monitor.
2000	DRSG Δ complete pt tolerated procedure
	well. Will continue to monitor.
6NOV03	Pt resting comfortably in bed, VSS, Will
0200	continue to monitor.
0600	Reported off to day shift.
6NOV03 @ 0650	pt report received from Sa[redacted] pt VSS, Assessment complete see bedside flowsheet
	for details pt ate apple for breakfast, no c/o pain @ present pt remains on 1L O2
	via N.C due to SPO2 ↓ without, will continue to monitor for s/s of acute distress

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO.

EPW# [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 23198

(b)(6)-2 all

LAST NAME	FIRST NAME	INITIAL	ID NUMBER

DATE	NOTES
06 NOV 03	pt dressing Δ's completed pt tolerated well dressing CDI pt VSS No problems @
@ 1025	present pt show No s/s of ~~acute~~ acute distress @ this time will continue
	to monitor
@ 1730	pt weaned off O_2 pt SpO_2 @ 100% on RA $\bar{p}$ 2° off no O_2 will
	continue to monitor
1800	Received report from day shift. Pt appears
	to be resting comfortably in bed. VSS, TL to
	(R) EJ (+) flush $\bar{c}$ NS $\bar{c}$ 20KCL through blue port
	@100cc/hr. Suprapubic cath draining
	quantity sufficient clear yellow urine. Will
	continue to monitor.
2300	DRSG Δ complete, Pt tolerated procedures
	well. Areas look pink $\bar{c}$ white splotches.
	Areas of pus around the anus. VSS.
7 NOV 03	Will continue to monitor SPC, 91W M
0300	Pt appears to be resting comfortably
	in bed. VSS Will continue to monitor
0600	Reported off to day shift.
0615	Report + care of patient from previous shift received.
	Pt sleeping in bed. VSS. ⊗ s/s of pain or discomfort
	will cont to monitor
0830	Dsg Δ's to Abdomen + (R) groin completed. Pt received
	2mg MSO_4 for pain. Dsg Δ's td. well. VSS ⊗
	will cont to monitor

STANDARD FORM 509 (REV. 5/1999) BACK

USAFA V1.00

MEDCOM - 23199

ACLU-RDI 1675 p.160

DOD-036776

(b)(6)-2 except for very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
0600	Recieved report from Spc. [redacted]. Pt resting in bed on (L) side c lips opened. Bandage intact to abd & (Rt) groin area. ⊖ complaints of pain voiced @ present time. Cather intact draining s difficult. Will continue to monitor. [redacted]
0705	MD visit. New orders noted. [redacted]
0752	Incentive Spirometery done @ this time. All 3 Balls up x 7. Will continue to encourage. [redacted]
	Progress Note - Urology
	Took down penile dressing
	wound intact
	healing well - minimal drainage of Scrotum
	Plan: Foley drainage x 10 days
	Penrose x 7 days
	[redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO. | WARD NO.

EPW # [redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

STANDARD FORM 509 (REV. 5/1999)
Prescribed by GSA/ICMR FPMR (41CFR) 101-11.203(b)(10)
USAPA V1.00

MEDCOM - 23200

(b)(6)-2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
7 Nov '03	dsg for a little scratch on (L) flank (+) circulation, skin intact restraints x2 in place. ——
1NOV@2340	VSS. Premedicated pt c̄ 4mg MSO4 prior to DSG Δ. WTD DSG completed to Abd, scrotum + (R) groin. Abd sutures well approximated c̄ ⊖ s/sx of infection. (R) groin packed c̄ NS soaked gauze. Sutures approximated (R) scrotum sutures approximated. Placed NS soaked gauze + used scrotum bandage to reinforce. Pt tol DSG Δ well. Suprapubic catheter in place. ⊖ s/sx of skin infection. Suprapubic draining clear, yellow urine. Clear, yellow drainage noted ~~arouneon~~ on DSG around penis. Did not Δ 2° no MD order to Δ DSG to penis. Infusing IV ABX as per order. Pt consumed small amount of food. IV maintenance fluid LR @ 75cc/hr Pt asleep + ⊖ c/o pain at this time. ——
8NOV03	Surgery HD#6 POD#5 Levaquin / Vanc D#6 Doing well No issues Wounds healing. Excellent BS, ⊕BM Will continue c̄ dressing Δ's

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
7NOV03	Surgery HD#5 ICU#5 POD#4 Levaquin/Vanc D#5
	Pt. has done very well overnight. No issues.
114/6 ϕ72	Will transfer to ward today. Continue
4.5 | 24 | ϕ8	dressing Δ's. Dr. [redacted] will eval penile
6.3 | 7.6 / 30.4 | 127	injury
	[redacted]
	X-rays of RLE = ϕ [redacted]
	Mild swelling of RLE $\bar{p}$ groin injury [redacted]
7Nov '03	pt arrives from ICU 1145 [illegible], A+Ox3 pt had mild
	c/o pain when moving from wheelchair to bed. pt numerous drsg
	Δ'd prior to admittance. Pt drsg appear CDI. pt voided
	medium/dark urine via urinal. ⊕PERRLA, skin intact
	good perfusion, lungs CTA, but breathing appears labored
	with slight audible wheezing. Bowel sound x4 quads.
	Pt has suprapubic catheter intact, with wound jockstrap sort
	drsg under scrotum and a drsg on the penis which is
	changed by the doc. Drsg down the [redacted]

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST / FIRST / MI | SPONSOR'S ID NUMBER (SSN or Other)

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PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

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PROGRESS NOTES
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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
8 NOV 03	- Assumed care of pt. sleep yet easily arousable
0700	VSS Denies having pain @ this time. lungs clear HRRR
	Active BS small BM this morning. Superpubic catheter to
	abdominal wall drainy QS clear yellow urine. Urethra
	c̄ catheter clamped. Multiple GSW to abdomen Ex Lap
	done midline incision closed c̄ staples healing. (R) inner
	thigh and penis testicle removed. scrotum support under
	wear. QD shower per MD. promote wound healing. Remains
	Afebrile IV ABT IV will cont to monitor [redacted]
8 NOV.03	Pt A+OX3, VSS, midline abd incision ∅
2030	s/sx of infex, staples intact, area tender
	dsg to abd Δ'd, W→D, [redacted] wounds beefy
	red, scrotum support in place, dsg to scro-
	tum blood tinged, pain controlled c̄ 2/11 percs,
	IS @ bedside, pt understands proper use,
	ate 40% of diet, FTG draining C/Y/U, 2 point
	restraint, ∅ complications. [redacted]
2045	Pt ambulated c̄ walker assistance, ambul-
	ated on the tip of toes, tol well but
	painful. [redacted]

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(b)(6)-4

MEDCOM - 23203

(b)(6)-2 except very bottom

LAST NAME | FIRST NAME | MIDDLE INITIAL | ID NUMBER

DATE	NOTES
9NOV03@1600	Assumed care of pt. @ 0600. Pt. resting quietly in bed, V.S.S. Ø C/O pain, A+O. DRSNGs to abdomen & groin removed & pt. assisted to BR for shower, unsteady gait. Pt. assisted back to bed & DRSNG reapplied. W→D drsgs applied to abdomen, superficial wounds, small amt. sero-sang. drainage. Bacitracin applied to open urethra, Foley Stent intact, Dry Kerlex to scrotum incision, penrose intact, serous drainage, scrotal support intact, [redacted] suppository @ 1000, ⊖ BM this shift, hypoactive BS. Pt. in 2-point restraints Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor. [redacted]
9 NOV03 @1800	Pt. has suprapubic catheter draining dark yellow urine, 1500cc out this shift. 1-2+ pitting edema to (R) foot. Pt. ambulates to BR, on toilet at this time. [redacted]
9NOV.03 1930	Pt A+Ox3, VSS, OOB → ambulate, ambulates c̄ slow unsteady gait, able to ambulate on his own, dsg on abd wound Δ'd, serosang drainage noted on old dsg, wound appears beefy red, packed c̄ W→D dsg, covered c̄ 4x4's, staples to midline abd incision CDI, Ø s/sx of infex, dsg around penis + [redacted] scrotum Δ'd, drainage on old dsg, applied bacitricin to urethra and incision on scrotum, pen rose drain intact, cath clamped in place, SP cath draining CYU, pain controlled c̄ ii percs, IV (L) FA intact infusing LR @ 75 cc/hr, Ø s/sx of infex, scrotal support underwear in place. I concur c̄ above assessment [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Cont.	2 point restrain, Ø complications
09NOV03	I concur ē above assessment
10NOV03	Surgery HD#8 POD#7 Levaquin/Vanc [illegible] #8
	Afebrile
	Wound healthy
	Continue Dressing [illegible] showers
10NOV03 1045	[illegible] Ambulated ē assistance on ward for 30 min. Performed self care and showered after DSG's removal by MD - Dr. [redacted] Abdominal, Ⓡ inner thigh, upper Ⓛ torso wounds and urethral wounds appear pink and beefy ē s/s infection, malodor or overt bleeding. SP catheter intact ē gravity flow - light amber, [illegible] Staples to abdominal incision CDI as well to Ⓡ inner thigh. Catheter through urethral opening intact ē s/s of infection. Minimal drainage of serosanguinous fluid.

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PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
10 NOV 03 1900	Pt A+O x3, VSS, LS CTA (B), Hypoactive BSx 4 quads, pain controlled c̄ percs, IV + (L) FA intact, infusing LR 75cc/hr, ø s/sx of infex or infiltration, staples to midline abd incision CDI, tender on abd, abd wound dsg Δ'd, appears beefy red granulated tissue, ø s/sx of infection, WTD dsg c̄ 4x4's covering it, (L) flank 2x2 dsg Δ'd, ø active bleeding or s/sx of infex, dsg's around penis + scrotum Δ'd, serosang drainage noted on old dsg's, penrose intact, bacitricin applied to urethra area, cath tip inserted + clamped, SP cath site ø s/sx of infex, SP draining CYU, supportive underwear in place, dsg on (R) groin Δ'd, moderate drainage on old wound, WTD dsg, 2 point restraint ø complications. [redacted]
11 NOV 03 @ 0830	Pt. A+O x3, V.S.S., ø c/o pain. All [redacted] removed, pt OOB to shower, ambulates c̄ assistance, slight unsteady gait. Midline incision, well approximated c̄ staples intact. Abdom. wounds red c̄ yellow exudate. (R) inguinal wound red c̄ yellow exudate, scant serosang. drainage to old penile dsng. Foley stent intact, visible from open urethra on ventral side of penis. Supra pubic catheter intact draining clear yellow urine. Pt. reported (+) BM this AM, ø diarrhea or constipation. Will redress wounds p̄ pt. takes shower. [redacted]
11 NOV 03 @ 1030	All dressings Δ'd as per MD orders, 1-2+ pitting edema to (R) foot, (R) LE elevated on blanket, LR @ 75cc/°, All other assessments WNL [redacted]

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ACLU-RDI 1675 p.167

DOD-036783

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11 Nov 03 2300	Assumed care of Pt @ 1800 hrs. A&O Pain controlled c̄ percocet, LS CTA (B), IS 10xh when Awake. HRRR. (+)BS x 4 quads. SP cath Draining c̄/y/u. Foley cath acting as stent No Drainage. Midline Abd incision closed c̄ staples. Wound superior to incision Pink c̄ yellow Drainage on Drsg. W→D Drsg Δ'd. Wound to penis c̄ yellow Drainage on Drsg. Appears pink & healthy covered c̄ Kerlex fluff c̄ coban. Wound to R Inguinal area pink and healthy in appearance W→D Drsg Δ'd. Kerlex fluff to scrotum Δ'd scrotum incision closed c̄ sutures. No s/sx of infection noted on any wounds or incisions. Penrose Drain to scrotum intact and inplace. (R) Foot has +1 pitting edema (R) Foot elevated. (+) 2 pulse. Warm & Dry to palpation. Will continue to monitor [redacted]
12 NOV 03	Surgery HD#10 POD#9 Levaquin D#9 Doing Well; Abd incision healing well. will remove staples in 2 days; Abd wound c̄ good granulation. Groin wound healing well. will leave sutures for 14 days. Scrotum c̄ drain still in place + some exudate.

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST, FIRST | SPONSOR'S ID NUMBER [redacted]

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PROGRESS NOTES
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(b)(6) - 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
12NOV03 1210	VSS, AO. Ambulated on own accord to shower. Seen by MD and DSG Δ's performed. Provided clean clothes, sheets and scrotal support. H&IV per Dr. Rx. IV AB D/C'd and ∆'d to PO. Expressed concerns over missing family @ this time. MD stated wounds are healing well and appear to close Ⓡ inguinal and abdominal incisions in a couple of days. ∅ S/S of infection to wound sites. ∅ S/S skin breakdown. Cont to monitor. — [redacted]
12NOV Ø3 2300	VSS A&O. DSG's Δ'd. Scrotal support inplace ē Kerlex Fluff. Encourage IS, PO Fluid intake. Pt Denied pain @ this time. LS CTA Ⓑ, HRRR. ⊕ BS x4 quads. S/P cath inplace Draining clear yellow urine. HL To ⓇFA. Will continue to monitor. — [redacted]
13NOV03 1220	VSS, AO. Ambulated to shower on own accord ē difficulty. DSG Δ'd to wounds s̄ healing well. Bacitracin applied to urethral catheter and opening. LSCTA B. HRR. ⊕ pulses in all extremities. BS ⊕x4 and tolerating PO well. Stated c/o pain p̄ DSG Δ and provided [illegible]. S/P cath intact and voiding light amber urine, BS. [redacted] ∅ S/S of skin breakdown — [redacted]
13NOV.Ø3 2000	Pt AtoX3, VSS, OOB to BR, SP cath site intact, draining CYU, dsg's Δ'd, abd wound healing well, ∅ S/Sx of infex, minimal amount sero sang drainage to dd dsg. Ⓡ groin wound packed ē WTD, ∅ S/Sx of infex, staples to mid line abd CDI, cath tip in place. Bacitricin applied to urethra covered ē 4x4, supportive underwear in place, ∅ S/Sx of skin breakd

I cmc: ē above a/o. [redacted]

STANDARD FORM 509 (REV 6/1999) BACK

MEDCOM - 23208

ACLU-RDI 1675 p.169

DOD-036785

(b)(6) - 2 except very bottom

AUTHORIZED FOR LOCAL REPRODUCTION

MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
14NOV03	Surgery HD#12 POD#11 Levaquin D#11
	No new issues. Wound, healing well
	Staples removed. Pt. is an EPW &
	will have to remain here until wounds
	closed
14NOV03 @ 1600	Assumed care of pt @ 0600, V.S.S., A&O x 3, ii Percocet given for dressing Δ. MD removed staples to midline abdominal incision, Ø drainage, edges well approx. All DRSNGs Δ'd as per MD order, Ø signs of infection. ⊕1 pitting edema to Ⓡ LE (mid) foot. Ⓡ LE elevated on blankets. Supra pubic catheter intact → clear yellow urine. Pt. ambulates s̄ assistance, limps on Ⓡ foot. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL.
14 Nov 03	Assumed care @ 18hours. VSS A&O Perc For pain. Drsg Δd. Ø S/Sx of infection noted. +1 pitting edema to Ⓡ Foot LS CTA Ⓑ, HRRR, ⊕ BS x 4 quads. Will cont to Monitor.

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REGISTER NO.	WARD NO.

PROGRESS NOTES
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(b)(6) - 2 except very bottom

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
15 NOV 03	Surgery HD#13 POD#12 Levaquin D#12
	Abd + groin wounds healing well
	May try to loosely approximate these
	wounds tomorrow
15 NOV 03 1600	Assumed care of pt. @ 0600. VSS, A&O, PERCS for pain,
	DRSNG Δ's. All DRSNG's Δ'd as per MD order, Ø signs of
	infection noted. Pt. OOB to BR to shower & use toilet.
	⊕ BM. ⊕1 pitting edema to Ⓡ LE, elevated c̄ blanket in
	bed. Pt in 2-point restraints, Ø signs of skin breakdown.
	Supra-pubic cath intact → CYU. All other assessments
	WNL. CT, ANC
2210 -	assumed care of pt. @1800. VSS - A+O. drsng
	Δ's conducted. W→D to Abd. wound + Ⓡ LE.
	⊖ S/Sx inf. Drsng Δ completed to penis.
	Bactracin applied + wrapped c̄ Coban.
	⊖ S/Sx infection. ⊕ edema to Ⓡ Foot. Elevated
	c̄ Blanket. Foley intact. Supra pubic intact
	draining CYU. Pt. resting well @ this time
	will cont. to monitor.
	I concur c̄ above assessment
16NOV03	(0908) VSS. ii percocet for pain. Pt tol DSG Δ well. Packed
	DSG to Ⓛ side of mid-line abdominal incision. Dr [redacted] viewed
	wound. Dr [redacted] stated that he planned to close abdominal
	wound. ⊖ new orders pending. W→D DSG to Ⓡ groin.

STANDARD FORM 509 (REV. 5/1999) BACK
USAPA V1.00

(cont)

(b)(6)-4

23210

(b)(6)-2 except for very bottom

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
17NOV03	(1025) NSG - VSS. Pt amb to BR c̄ steady gait. Pt did own AM care. WTD DSG to ABD + Ⓡ groin. Applied Bacitran to underside of penis + wrapped c̄ super sponge. Yellow catheter in place. Suprapubic catheter intact + draining clear, yellow urine. ⊝ drainage noted around tubing. ⊝ s/sx of infection. c/o pain. Med c̄ ¼ perc. Pt asleep at this time. [redacted]
17NOV03	(1540) NSG - Spoke to DR. [redacted]. Requested to hold off on DSG Δ in AM 18NOV 2° MD will loosely suture ABD + Ⓡ groin wounds. — [redacted]
2120	- VSS - A+O LS CTA Ⓑ, Resp. even unlabored NSR, Abd soft nontender, BS x4 - drsng Δ completed, Bacatracin applied to underside of penis + wrapped c̄ 4x4's + Kerlex. WTD drsng done to Ⓛ side midline incision + Ⓡ groin area. ⊝ s/sx infection. Pt. voiding per supra pubic cath. Foley catheter in place. ⊝ drainage noted around tubing. Two pt. restraints in place c̄ ⊝ skin breakdown ⊕ circulation. Will cont. to monitor pt — [redacted]

[redacted] (b)(6)-4

STANDARD FORM 509 (REV. 5/1999) BAC
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ACLU-RDI 1675 p.172

DOD-036788

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
18NOV03	(1440) NSG - VSS. c/o pain. Medicated c̄ ii perc tabs c̄ adequate relief. Completed DSG Δ. ⊖S/Sx of infection. Bacitran applied to underside of penis. Scrotal support in place. Pt amb on ward x 1 c̄ steady gait. (+) suprapubic catheter intact, drains clear, yellow urine. [redacted]
18 NOV 2000	VSS. Tissue to open wounds pink & moist. Bacitracin applied to incision to underside of penis. Dry drsg wrapped around penis. suprapubic cath intact & draining clear yellow urine. Amb → BR, had BM x1. Scrotal support in place. Will continue care as planned – [redacted]
19NOV03	Surgery HD#17 POD#16 Levaquin D#16 Doing well. Will approximate the abdominal + groin wounds today. Foley to be removed in 5-7 days. [redacted]
19NOV03 @ 1440	Assumed care of pt. @ 0600. VSS, A+O. ii Percocet for pain & pre-med for dressing Δ. Pt. OOB to shower, ambulates c̄ assistance. MD closed abd. & (R) inguinal wounds c̄ sutures after

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(b)(6)-4 [redacted]

PROGRESS NOTES
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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	pt. took shower, edges well approx., scant sero-sang drainage, covered c dry gauze. Dry dressing Δ to penis, Kerlex fluffs to scrotum, scrotal support on, Suprapubic cath intact → CYU. (R) LE elevated on blankets. Pt. in 2-point restraints, Ø signs of skin breakdown. All other assessments WNL. Will cont. to monitor, ——— [redacted] LT AN
19NOV03	0030 assumed care of pt. @ 1800. Pt. tolerated dinner well. No c/o pain @ this time. drsng Δ completed to (L) side of mid line incision + (R) groin area. Sutures intact, well approximated c (−) s/sx inf. dry drsng applied to penis + scrotum wrapped c Kerlex. (−) s/sx inf. Pt. has foley in place. Supra pubic intact draining CYU. Two pt. restraints in place (−) skin breakdown, (+) circulation. Will cont. to monitor pt. [redacted]
	I concur with above assessment [redacted]
20NOV03	0750. BP 117/56, P-51, 98% RA, R-16
20 NOV03	POD #17
	No new issues [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

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DATE	NOTES
20NOV03	(1500) NSG-VSS. Pt c/o pain to sutures on abdomen + (R) groin. Premedicated pt ō 2mg MSO4 IV prior to DSG Δ. Dr. [redacted] viewed sutures. MD ordered to pack lightly suture to (R) groin. Sutures are loosely sutured ō ⊖ s/sx of infection. Dr. [redacted] removed sutures to Suprapubic cath. Suprapubic intact + draining clear, yellow urine. Pt amb on ward c̄ steady gait. No Bacitracin applied to penis 2° Dr. [redacted] request. Pt appears to be comfortable at this time. Will contine to monitor pain. [redacted]
2250	assumed care of pt. [redacted] @1800 VSS-AVO pt has ∅ c/o pain @ this time. LS CTA (B), resp even unlabored, NSR, abd soft nontender, BSx4. voiding c/y per supra pubic, foley in place. sutures to (L) of midline incision intact. Sutures to (R) groin intact. packed lightly covered c̄ 4x4's. Dry gauze applied to penis + scrotum. ∅ s/sx infection. pt. ambulated in hallway x20mins. Tol. well. Two pt. restraints in place s̄ skin/circ. compromise. Will monitor. [redacted]

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USAPA V1.00

MEDCOM - 23214

(b)(6) - 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
~~20N~~ 21NOV	(0700) 124/55, 61, 98% RA, 20, 96.8 — [illegible]
21NOV03	Surgery POD#18
	Doing very well. Abd + Groin wounds
	approximated. Will remove Foley in 4-7 days
	[illegible]
21NOV03	(1700) NSG - VSS. Pt. c/o pain to (R) groin + ABD. Med $\bar{c}$
	2mg MSO4 prior to DSG Δ. Suture to ABD well approximated.
	~~Ste~~ Cleaned $\bar{c}$ H_2O_2 + covered $\bar{c}$ dry DSG. (R) groin suture has
	1/2 cm openning. Lightly packed WTD + covered $\bar{c}$ dry DSG.
	2x2 gauze placed on underside of penis. (R) suprapubic
	cath intact draining clear, yellow urine. [illegible]
21Nov@0355	Assumed care @1800; VSS, pt A&O speaking arabic; Ø c/o pain/discomfort @ this time
	abd sutures ~~[illegible]~~ CDI, well approximated, ~~cleaned $\bar{c}$ H2O2~~ ERROR & dry dsg placed over; dsg to (R)
	groin Δd W→D, lightly packed; 4x4 placed to underside of penis; SP tube intact & patent
	draining clear, yellow urine; Restraints in place, ⊕ circ, Ø skin break↓,
	will cont to monitor [illegible]
22NOV03	Surgery POD#19
	Doing well. Wounds healing. Foley out tomorrow
	[illegible]
22 NOV 03 @ 1500	Assumed care of pt @ 0600, VSS, A&O, ii Percocet for c/o
	pain to (R) LE. Pt. OOB → shower. Dressings Δ'd as per MD order,
	Ø S/Sx of INFX. Supra pubic cath intact → CYU. Foley stent intact
	Pt. in 2 point restraints, Ø signs of skin breakdown. All other
	assessments WNL, Will cont. to monit — [illegible] 2LT, AN

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USAPA V1

MEDCOM - 23215

ACLU-RDI 1675 p.176

DOD-036792

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MEDICAL RECORD	PROGRESS NOTES

DATE	NOTES
11/22/03	Doing well
	Plan catheter removal tomorrow
	DC [illegible]
	DC [illegible]
	Wound continues to heal
	Plan remove foley
	VPVR

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

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PROGRESS NOTES
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MEDICAL RECORD | **PROGRE[SS N]OTES**

DATE	NOTES
23Nov03 0400	Assumed care @ 1800; VSS, pt A&O speaking arabic; pain controlled c̄ percs; All dsgs Δ'd per MD orders, ⊖ s/sx infection; SP tube in place, tube care provided SP tube draining clear yellow urine; Foley in place & clamped; Pt OOB to BR, Restraint in place, ⊕ circ, ⊖ skin breakdown; cont to monitor
23 NOV 03 @ 1130	Pt a/o, VSS, medicated c̄ percocet for pain @ 1000. Drsgs removed & pt showered. Drsgs reapplied SP tube intact, Dr [redacted] removed foley this AM. & ordered post void residual V's from SP cath. Heparin SQ & colace PO given per MD orders. ∅ s/sx infection noted from wounds. all other findings WNL. Will monitor
	[redacted] LPN.
1830	Pt has voided x2 out of penile opening (urethral) unable to measure amount voided both times. Residual V's recorded on I/O sheet - [redacted]
23 NOV. 03 1930	Pt A+Ox3, VSS, dsg's on penis, Ⓡ groin + abd Δ'd, scant amount of drainage noted, pain controlled c̄ percs, SP intact, ∅ s/sx of infex on SP cath site. [redacted] ∅ s/sx of infex on wounds. [redacted]
	Concur c̄ above assessment [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME — LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	(cont) ⊝ s/sx of infection. Sutures to (R) groin well approximated
	⊝ s/sx of infection. Sutures to scrotum ⊝ s/sx of infection +
	Well approximated. 2x2cm openning on underside of penis.
	Bacitran applied + wrapped c̄ super gauze, held c̄ koban.
	Scrotal support in place. Pt amb on ward c̄ steady gait.
	~~(+) Foley draining clear, yellow~~ error Suprapubic catheter in
	place draining clear, yellow urine. Catheter intact. Very
	minimal amt of yellow drainage around catheter. [redacted]
2315 -	assumed care of pt @ 1800. VSS-AFO! ∅
	c/o pain at this time. drsng Δ completed
	to (L) side of mid-line incision. packed
	w→D. ⊝ s/sx infection. Drsng to (R)
	femural area Δd. w→D. sutures intact
	⊝ s/sx inf./Redness. [redacted] drsg Δ done to
	underside of penis. Batracin applied.
	wrapped c̄ 4x4's + Koban. ⊝ s/sx infection.
	Scrotal support in place. suprapubic
	catheter in place draining clear yellow
	urine. foley in place, intact. ∅ complaints
	@ this time. (+) edema to (L) foot.
	elevated c̄ blanket. Will cont. to monitor. [redacted]

RELATIONSHIP TO SPONSOR — SPONSOR'S NAME: LAST / FIRST / MI — SPONSOR'S ... [redacted]

[illegible] above assessment [illegible]

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO. | WARD NO.

PROGRESS NOTES
Medical Record

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[redacted]

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
24NOV03 @1330	Pt a/o, VSS, medicated c̄ percocet for pain. Pt has not voided from urethra since last night. Residual v/s being done from SP cath & amt documented on I/O sheet. ∅ bladder distention noted. Pt showered & drsgs Δ'd. Small amt. serous drainage to penile drsg. Abd & Ⓡ groin wound c̄ ∅ drainage. Pt amb x2. Tol Reg diet well. ⊕ appetite today. Will monitor. [redacted]
25NOV03 @0200	Assumed care of pt @1800. VSS. no c/o. Alert, LS CTA, ⊕BS, tol po well. Voids per SP cath. Through interpreter, pt states he doesn't like voiding through urethra d/t messiness when it leaks. Will notify MD. ML abd inc x2 OTA, small dry drsg applied, sutures in place. Ⓡ groin drsg Δ'd, sm amt serosang drainage noted. Scrotal & penile incision c̄ WTD drsg Δ, ⊘ drainage noted, sutures noted in penile wound. 2pt restraints in s̄ s/sx of skin/circulation compromise. Plan: monitor drsg, pain control. Addendum: Ⓡ foot noted c̄ +1 edema ⊕ DP pulse, equal (bil). [redacted]

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ACLU-RDI 1675 p.180

DOD-036796

(b)(6)-2 all except bottom

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
	Surgery
25NOV03	POD #22
	Ⓢ No New issues. Sutures removed from Ⓡ groin wound and will continue dressing changes. Probably 5-7 days before transfer to camp.
	[redacted]
25 NOV @0950	Pt a/o, VSS, c/o pain, controlled c̄ percocet. Dr [redacted] came & spoke c̄ pt. WTD drsg to Ⓡ groin per MD. [redacted] removed sutures today & wound is not closing completely. Small amt sero-sang drainage noted. Midline abd incision now OTA, ø drainage noted. Penile & scrotal drsg Δ'd, scant yellow drainage on drsg. Post void residual V's con't. SP intact - drsg Δ'd. ø s/sx infections to wounds. Will monitor. [redacted]
23 NOV 03 2000	Pt A+Ox3, VSS, LS CTA Ⓑ, ⊕ BSx4, percs adm. for pain, dsg Ⓡ groin Δ'd, ø s/sx infex on wound, fluff placed around penis, SP cath clamped in place, ø s/sx of infex around site, scant amount

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST / FIRST / MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)* | REGISTER NO. | WARD NO.

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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(b)(6) - 2 all

LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont.	serosang drainage on old dsg. OOB
	to ambulate, tol well. [redacted] GM
2300	Pt voided 275cc CYU, [redacted] urine output
	from SP cath. ——— [redacted]
	I concur c above assess [redacted]
	Urology
	SP out this AM
	PVR's ↓100
	Plan to Camp when leg wounds heal
	2nd stage repair in 3-6 months
	[redacted]
26 NOV 03	Assumed care of pt sleep yet easily arousable
0830	A+O x3. VSS Ø c/o pain or discomfort @ this
	time Lungs clear HRRR Active BS x4 quads
	Urinating through his urethra spontaneously. Wound to
	(R) groin region healing 4x4 gauze CDI Wound to penis
	4x4 gauze small amounts of serous drainage. Suprapubic
	catheter dc'd per MD. Will cont to monitor [redacted]
27NOV03	assumed care of pt @ 1800. VSS. no c/o pain. Pt ↑AMB
@ 2300	to BR/in hallway s assist. voiding per urethral wound
	(underside of shaft) QS, but refuses to void in urinal
	D/T lack of control of spray. Dry drsg to urethral wound
	applied i (R) groin wound, s drainage. Ø pt restraints on
	s s/sx of skin/circulation compromise. CONT [redacted]

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ACLU-RDI 1675 p.182

DOD-036798

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
27NOV03 @0300	(CONT) Tol reg diet well, ø other issues. Plan: monitor output, enc fo intake, enc OOB. Will monitor.
27NOV03	Surgery AVSS No New Issues Once wounds healed, will transfer to EPW camp.
27 NOV 1110	Pt A/O, VSS, medicated c̄ percocet for pain @0900. drsgs Δ'd Ⓡ groin c̄ scant sero-sang drainage. voiding thru urethral wound, unable to document I/O's due to lack of control. Dry drsg over previous SP cath site. Pt amb. s̄ difficulty. Plan: monitor drsgs & any difficulty voiding. Will monitor.
27NOV03 1900	Pt A+Ox3, VSS, pain controlled c̄ percs, voiding through urethra s̄ difficulties, wound Ⓡ groin dsg Δ'd, scant amount sero-sang drainage, SP cath old site ø s/sx of infex,

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

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PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
Cont.	
0430	Pt c/o pain, adm 2 percs as per [illegible] ers. will continue to monitor.
	[illegible]
28NOV03	Surgery Healing well Silver Nitrate Stick to Right groin wound to decrease granulation & assist healing
28NOV03	(1535) Assumed care @ 0800. Pt alert, speaking Arabic. VSS. Ø c/o pain. OOB to shower this am. Dry dsgs applied to ® groin and underside of penis. Ø S/Sx of infection. Pt amb in hallway s̄ diff. Tol reg diet well. Voiding s̄ difficulty through urethral wound. 2 point restraints in place s̄ S/Sx complications. will cont. to monitor.
28NOV03 1830	Pt A+Ox3, VSS, OOB to BR, silver nitrate sticks used for ® groin wound, scant amount sero sang drainage noted on old dsg. Ø s/sx of infex on wound or urethra, voiding s̄ complications, percocet adm to relieve pain.

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MEDICAL RECORD | **PROGRE[ ]OTES**

DATE	NOTES
29NOV03	(2000) Assumed care @ 0000. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOB to BR this am for shower. Dsg applied to groin p̄ silver nitrate stick applied by MD. Fluffs placed between scrotum and penis. Pt voiding s̄ diff. Amb in hallway s̄ difficulty. Tol. reg diet well. 2 point restraints in place s̄ s/sx complications. Will cont. to monitor.
29NOV.03 2030	Pt AOx3, VSS, #ii percs adm for pain relief, OOB → BR, voiding s̄ difficulties, dsg on (R) groin Δ'd, scant amount sero sang drainage on old dsg, Ø s/sx of infex on wound, fluffs placed between penis + scrotum.
30NOV03	Surgery. No new issues. Continue to follow (R) groin wound

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.

WARD NO. ICW

[redacted] (b)(6)-4

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
30NOV03	(1600) NSO. VSS. c/o pain x1. Med c̄ ii percocet. Will continue to monitor. Pt showered. Redressed (R) groin c̄ dry fluff (-) signs of infection. Voids in urinal s̄ difficulty. Pt tol po well. Amb c̄ steady gait. Limps on (R) Leg. [redacted]
30NOV03 2045	Pt AtOx3, VSS, percs adm for pain relief, dsg (R) Δ'd, scant amount sero sang drainage noted on old dsg, wound s̄ s/sx of infex, fluff placed between penis + scrotum, OOB → BR, voiding s̄ difficulties, urethra appears healing well s̄ s/sx of infex. [redacted]
1 Dec 03	Assume care of PT @ 0600. AtO, VSS c/o pain given percocets. Ambulate s̄ assistance. Showered, redressed (R) groin, CDI. Void c/y urine. In 2pt restraint s̄ skin breakdown. Will cont to monitor. [redacted]
2Dec03 @ 0500	Assumed care @ 1800; VSS; pain controlled c̄ percs, pt alert + speaking arabic; all dsgs CDI; pt OOB → BR x2, amb in hall x1 s̄ difficulty; pt tol Reg diet, voiding s̄ difficu[lty] Restraints in place s̄ skin/circ ~~compromise~~ compromise; cont to monitor [redacted]
2DEC03	Doing Very well Awaiting closure of very small groin wound [redacted]

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
Ø2DECØ3	(1Ø15) Assumed care @ ØØØØ. Pt alert, speaking Arabic. VSS. Pain controlled c̄ Percs. Pt OOB to shower this am. Amb well. 4x4 placed on Ⓡ groin wound. Ø S/Sx infection. Pt voiding s̄ difficulty through urethra. Tol. reg diet well. 2 point restraints in place s̄ S/Sx complications. Will continue to monitor.
	Assumed care @ 1800; VSS, pt Alert + speaking arabic; pain controlled c̄ percs; Pt OOB to amb in hall & to BR s̄ difficulty; dsg to Ⓡ groin CDI; pt Tol Reg diet well; voiding s̄ difficulty; Restraints in place s̄ compromise to skin/circ; cont to monitor
3DEC03	assumed care @ 0600 pt awake + oriented x3 VSS. pt has Ø c/o pain at this time pt up and ambulating without difficult, Ⓡ groin dsg CDI after pt's shower, restraints x2 in place Ⓢ skin breakdown Ⓟ circulation.
	(1345) I concur c̄ above assessment.
3DEC03 Ⓝ 2340	Assumed care of pt @1800, VSS, no c/o. Alert, speaking arabic. LSCTA, tol reg diet, ambs assistance, but drags Ⓡ foot. Ⓡ groin wound small approx 1.0cm x 1.0cm x 0.5cm Ø drainage noted, dry drsg applied. Wound (CONT)

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME — LAST	FIRST	MI	SPONSOR'S ID NU (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

#[redacted] (b)(6)-4

REGISTER NO.

WARD NO. ICW1

PROGRESS NOTES
Medical Record

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LAST NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
3DEC03 2340	(CONT) to underside shaft of penis OTA, sutures noted & intact. Voiding s̄ difficulty. Teary/crying @ ≈ 2200, refusing Heparin & colace. Explained through interpreter importance of Heparin. Pt stated he wanted to return to EPW camp. 2pt restraints on s̄ S/Sx skin/circulation compromise. Plan: monitor pain, enc OOB, enc po.
4DEC03 0700	Assumed care of pt @ 0600 pt sleeping. Pt awake + oriented x3, pt has no c/o pain at this time, spoke to Dr about d/c'd hep but because of pt level of activity he still needs it, 1100 pt ambulates without difficulty and showers, drsg to ® groin CDI, restraints x2 in place ⊕ circulation ⊖ skin breakdown. Will monitor
4DEC03 1900	VSS Alert + Oriented Consumed 80% of dinner. ® groin drsg dry & intact. ∅ c/o pain or discomfort @ this time. OOB → BR Ⓘ upon supervision of MP's. Peripheral pulses +2. 2point restraints in place without compromising skin integrity or circulation. will continue plan of care
5DEC03	Surgery Wounds closed. Will [illegible] transfer summary. As soon as very [illegible] s/p wound of ® groin closed. May go to prison camp.

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
5 Dec 03 1450	Assume care of PT @ 0600. A+O, VSS c/o pain given ii percs. Ambulate and showers on own. 2pt restraint Ø skin breakdown. Dsg to (R) groin A&ed Δ, dsg 4x4 and tape. Area CDI. Will cont. to monitor.
	(1600) I concur c above assessment
5 DEC 03 (1900)	VSS Alert & Oriented. Dsg to (R) groin Dry & Clean. 2 point restraints inplace without compromising circulation in plain [illegible] voiding without difficulty. OOB ambulate to BR c supervision of MPS. Ø c/o pain voiced or noted. Will continue care as planned. 2LT AN
6 Dec 03 1350	Assume care of PT @ 0600. A+O, VSS c/o pain in (R) leg. Ambulate. A&ed dsg to (R) groin, dry dsg c 4x4. Wound has closed. 2pt restraints. Will cont to monitor. 2LT, AN
6 DEC @ 1800	I agree c previous assessment.
7 Dec 03 @ 0240	Assumed care @ 1800; VSS, pt alert speaking arabic; pain controlled c percs; dsg to (R) groin CDI, Θ drainage; pt TOl Reg diet; voiding s difficulty; pt amb to BR; Restraints in place s compromise to

RELATIONSHIP TO SPONSOR | SPONSOR'S NAME: LAST | FIRST | MI | SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE | HOSPITAL OR MEDICAL FACILITY | RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade) | REGISTER NO. | WARD NO.

(b)(6)-4

PROGRESS NOTES
Medical Record

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NAME	FIRST NAME	MIDDLE INITIAL	ID NUMBER

DATE	NOTES
	(cont) skin/circ; cont to monitor
7DEC03 0815	Assumed pt. care @ 0600. pt. A+O, speaking arabic, able to ambulate and shower on his own s̄ difficulty. VSS. pt. c/o pn on (R) foot. ⊕ PMS, FROM on (R) foot but walks c̄ a slight limp. Wound on groin area appears to be healing well. ⊖ s/sx of infex. dry drsg applied, very minimal to ⊖ drainage. Will continue to monitor ——— 91W10
7Dec03 2320	Assumed care @ 1800; VSS, pt alert speaking arabic, pain controlled c̄ Tylenol; dry dsg to (R) groin CDI, ⊖ drainage; pt OOB → BR; pt amb s̄ difficulty c̄ slight limp, pt seems to be favoring (R) foot; pt TOL Reg diet; voiding s̄ difficulty; Restraints in place s̄ compromise to skin/circ; will cont to monitor
8Dec03 0810	Pt c/o pain in (R) foot. A given II percocet per MD order. Will continue to monitor ——— 91WM6
8DEC03 0930	Assumed care @ 0600. pt. A+O, speaking Arabic. VSS. able to ambulate well and shower on his own. walks c̄ a limp on (R) foot. ⊕ PMS, FROM on (R) foot. Dry dsg applied to groin area wound. appears to be healing well c̄ no s/sx of infex. HRRR, LSCTA, BSx4. PO tol well. voiding s̄ difficulty no signs of skin breakdown on restraint and other prone areas ——— 91W10
8DEC03	Surgery Wound is Healed. Transfer to Camp tomorrow. No meds needed Follow up c̄ Urology in 3 months

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MEDICAL RECORD	PROGRES[illegible]ES

DATE	NOTES
8Dec03 1725	Pt given tylenol for pain per MD orders. [redacted] A1ICMG
Ø8DECØ3	(2336) Assumed care @ ØØØØ. Pt alert, speaking Arabic. VSS. Ø c/o pain. Dry dsg applied to (R) groin wound. Scant amount of drainage noted. Groin and penis wound s̄ s/sx infection. Tol reg diet well. Voiding s̄ difficulty. 2-point restraints in place s̄ s/sx complications. Will continue to monitor. [redacted]
9 Dec 03 0700	Assumed care of pt. A+O X3. VSS Denies having any pain or discomfort @ this time. Lungs CTA HRRR Active BS X4 quads Tolerating PO well. Urinating spontaneously s̄ difficulty. Wound to (R) groin and penis healing No s/s of infection open to air pt Afebrile Will cont to monitor [redacted] [illegible]
1300	Pt ok for discharge escorted by MP assessment findings WNL [redacted] [illegible]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME: LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: (For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)

REGISTER NO.	WARD NO.

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **PROGRESS NOTES**

DATE	NOTES
9 DEC 03	
1000	20 y/o M S/P GSW to (R) thigh
	perineum & penis. Urethra also
	injured. Suprapubic cystostomy
	performed. Wounds healing well.
	Suprapubic catheter D/C.
	Pt. voiding s̄ difficulty.
	Ambulating & tolerating diet
	Transfer to [redacted] unit. No meds.
	Plan: Urology f/u in 3 mon. [redacted]

RELATIONSHIP TO SPONSOR	SPONSOR'S NAME — LAST	FIRST	MI	SPONSOR'S ID NUMBER (SSN or Other)

DEPART./SERVICE	HOSPITAL OR MEDICAL FACILITY	RECORDS MAINTAINED AT

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade)*

REGISTER NO.	WARD NO.

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PROGRESS NOTES
Medical Record

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MEDICAL RECORD | **CHRONOLOGICAL RECORD OF MEDICAL CARE**

DATE	SYMPTOMS, DIAGNOSIS, TREATMENT, TREATING ORGANIZATION *(Sign each entry)*
3 NOV 03	Op Note
	Pre-op Dx = GSW to Abd; (R) groin + scrotum
	Post-op Dx = Negative Lap; (R) groin injury; scrotal injury
	Surgeons: [redacted]
	Indications = as above
	Procedure = Ex Lap; debridement of wounds + scrotum; (R) groin exploration
	EBL = 1000
	Fluids = Cry = 6 Liters + 1 unit PRBC's
	UOP = unmeasurable
	Findings = Negative Lap; Urethra injury Bilateral testicle injury; negative Right groin
	Drains = Supra pubic Cath + Foley cath
	Will need further surgery to penis for recon.
	Dressing 4's to open wounds
	[redacted]

HOSPITAL OR MEDICAL FACILITY	STATUS	DEPART./SERVICE	RECORDS MAINTAINED AT
SPONSOR'S NAME	SSN/ID NO.	RELATIONSHIP TO SPONSOR	

PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; ID No or SSN; Sex; Date of Birth; Rank/Grade.)*

REGISTER NO.	WARD NO.

CHRONOLOGICAL RECORD OF MEDICAL CARE
Medical Record
STANDARD FORM 600 (REV. 6-97)
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FIRMR (41 CFR) 201-9.202-1

(b)(6)-2 unless indicated otherwise

MEDICAL RECORD | **INTRAOPERATIVE DOCUMENT**
For use of this form, see AR 40-66, the proponent agency is the office of The Surgeon General.

1. PATIENT TRANSPORTED TO OPERATING ROOM VIA Litter BY [redacted]

2. PATIENT IDENTIFIED, RECORD REVIEWED AND PROCEDURE VERIFIED BY [redacted]

3. DATE 3 Nov 03 TIME PATIENT ARRIVED IN SUITE 1020

4. PATIENT IN ROOM TIME 1020 NUMBER Trauma OR

5. PREOPERATIVE EMOTIONAL STATUS

☐ CALM ☐ ANXIOUS ☐ EXCITED ☐ CRYING ☐ ANGRY ☐ WITHDRAWN ☐ OTHER *(Specify)*

COMMENTS: Allergies: unknown
pt. intubated.

6. NURSING PERSONNEL

ASSIGNED SCRUB	SGT [redacted]	RELIEF SCRUB	
ASSIGNED CIRCULATOR	MAJ [redacted] (Start - 1100)	RELIEF CIRCULATOR	CPT [redacted] (1030 - 1200)

7. POSITION AND POSITIONAL AIDS *(Specify)*

☑ SUPINE ☐ LITHOTOMY ☐ PRONE ☐ KRASKE LATERAL: ☐ LEFT SIDE UP ☐ RIGHT SIDE UP

COMMENTS:

8. SKIN PREPARATION

HAIR REMOVAL ☐ YES ☐ NO Dr. [redacted]
DONE BY: ☒ OR ☐ NURSING UNIT
METHOD: ☐ DEPILATORY ☑ RAZOR
☐ CLIP

COMMENTS: no nicks or cuts noted.

PREP SOLUTION *(Specify)* Beta / Beta
SITE: nipple line to BY WHOM: CPT Heil
SITE: knees BY WHOM: —

COMMENTS: no pooling of prep noted.

9. LOCATION OF EXTERNAL DEVICES

/// prepped area

LEGEND X Ground Pad – Safety Strap === Tourniquet

10. COUNTS MAJ [redacted] SGT [redacted]

C = Correct I = Incorrect

10. COUNTS		Initial Other**	First Closing Count	Final Closing Count	SCRUB	CIRCULATOR
Sponge	☑ Yes ☐ No	C	C	C		[redacted]
Needle Sharp	☑ Yes ☐ No	C	C	C		
Instrument	☑ Yes ☐ No	C	C	C	SGT [redacted]	CPT [redacted]
Other	☐ Yes ☒ No	—	—	—		

11. PATIENT IDENTIFICATION *(For typed or written entries give: Name - Last, first, middle; Grade; Date; Hospital or Medical Facility;)*

#

3 Nov 03

[redacted] (b)(2)-2

12. ELECTROSURGERY DEVICE(S) (ESU) ☑ YES ☐ NO

☑ ESU NO: Valleylab
GROUND PAD: BRAND Valleylab E7507
LOT NO: 68245 Exp 2005-02

☐ ESU NO:
GROUND PAD: BRAND
LOT NO:

☐ BIPOLAR NO:

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DA FORM 5179-1, OCT 87 REPLACES DA FORM 5179-1 (TEST), DEC 82, WHICH IS OBSOLETE. USAPA V1.01

(b)(6)-2 all

13. PROSTHESIS, IMPLANTS ☐ YES ☒ NO IF YES NAME: ID NUMBER; MANUFACTURER

14. MEDICATIONS/ORDERS

IRRIGATION/MEDICATIONS GIVEN IN OPERATING ROOM (NOT BY ANESTHESIA) YES ☐ NO ☒

MEDICATIONS/SOLUTION	DOSAGE	TIME	METHOD	PREPARED BY	GIVEN BY

WOUND IRRIGATION ☑ YES ☐ NO, TYPE(S): N.S.

OTHER ORDERS	TIME	CARRIED OUT BY

PHYSICIAN'S SIGNATURE

15. X-RAY IN OPERATING ROOM IF YES, SITE
YES ☐ NO ☒

16. LABORATORY SPECIMENS

SPECIMEN (S) YES ☐ NO ☒	NAME	NAME
FROZEN SECTION (FS) YES ☐ NO ☒	NAME	NAME
CULTURE (C) YES ☐ NO ☒	NAME	NAME
NAME	NAME	NAME
NAME	NAME	

17. TUBES, DRAINS/PACKING YES ☒ NO ☐

TYPE/SIZE	1. 16F Foley	2. 3/8 Penrose	3.
SITE	1. to gravity	2. Scrotum x2	3.

18. DRESSING/IMMOBILIZATION (Specify) ABD
Fluffs 4x8
- Coban Silk tape
- Scrotal Support

19. ADDITIONAL INFORMATION
WC
Surgeons: [redacted] Anesthesia: [redacted] Anesthesia Type:

Bovie Pad site intact pre-op [redacted]; post-op [redacted] Bovie Settings: Coag/Cut 30/30
Tourniquet Site intact pre-op N/A post-op ______
Tourniquet Time: Up ___ Down N/A

20. OPERATION(S) PERFORMED

Exp. Laparotomy, Scrotal Exploration, Groin wound I&D

21. PATIENT TRANSFERRED TO ICU [redacted] TIME 1410 METHOD Litter

22. REGISTERED NURSE SIGNATURE
[redacted] MAJ AN 3Nov03 [redacted] CPT

REVERSE OF DA FORM 5179-1, OCT 87 USAPA V1.01

MEDCOM - 23234

511-119

NSN 7540-00-634-4124

MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY

POST- DAY

MONTH-YEAR DEC 2003 | DAY 05 | 06 | 07 | 08 | 09

HOUR 0800 | 1930 | 2000 | 0700 | 2000 | 0700 | 0700

PULSE (O)	TEMP. F (•)	TEMP. C
	105°	40.6°
180	104°	40.0°
170	103°	39.4°
160	102°	38.9°
150	101°	38.3°
140	100°	37.8°
130	99°	37.2°
	98.6°	37.0°
120	98°	36.7°
110	97°	36.1°
100	96°	35.6°
90	95°	35.0°
80		
70		
60		
50		
40		

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD 18 18 16 18 16 16 18

Record special data only when so ordered

BLOOD PRESSURE 134/67 | 135/70 | 134/68 | 134/81 | 132/73 | 124/62 | 122/74

98.2 | 132/73 | H 64

72 | 98.1 | T 97.6

HEIGHT: | WEIGHT → | 97.5 | 98%

O2 SAT 99% | 98 RA | 98% | 99% RA | 95% RA | 96% RA 100% RA | RA

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO. ICW

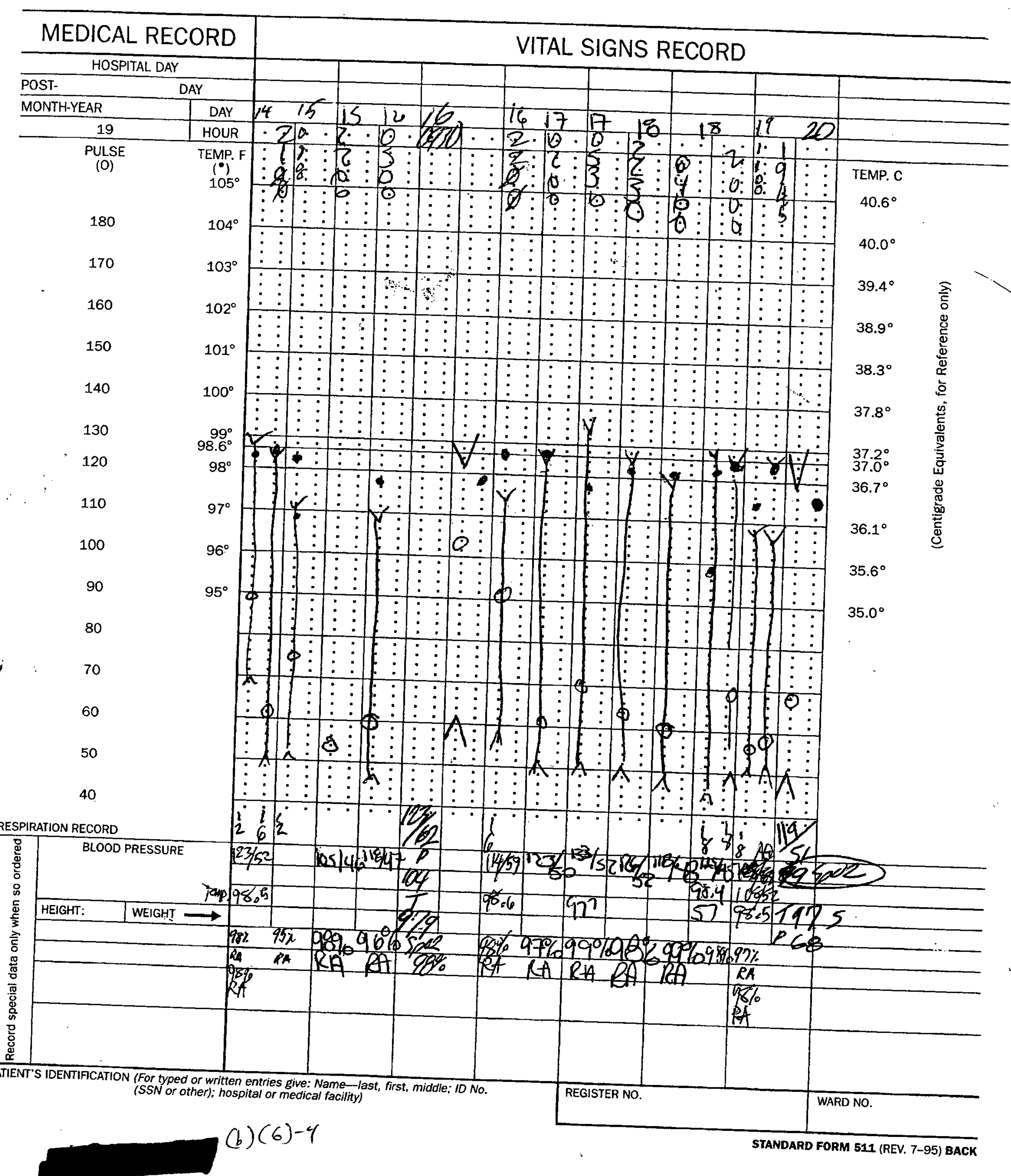
[redacted] (b)(6)-4

VITAL SIGNS RECORDS

Medical Record

MEDCOM - 23235

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1


MEDICAL RECORD

VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR DAY 14 15 15 16 16 16 17 17 18 18 19 20
19 HOUR

PULSE (O) TEMP. F (•)
180 104°
170 103°
160 102°
150 101°
140 100°
130 99° 98.6°
120 98°
110 97°
100 96°
90 95°
80
70
60
50
40

TEMP. C 40.6° 40.0° 39.4° 38.9° 38.3° 37.8° 37.2° 37.0° 36.7° 36.1° 35.6° 35.0°

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD
BLOOD PRESSURE
HEIGHT: WEIGHT →
Record special data only when so ordered

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.
WARD NO.

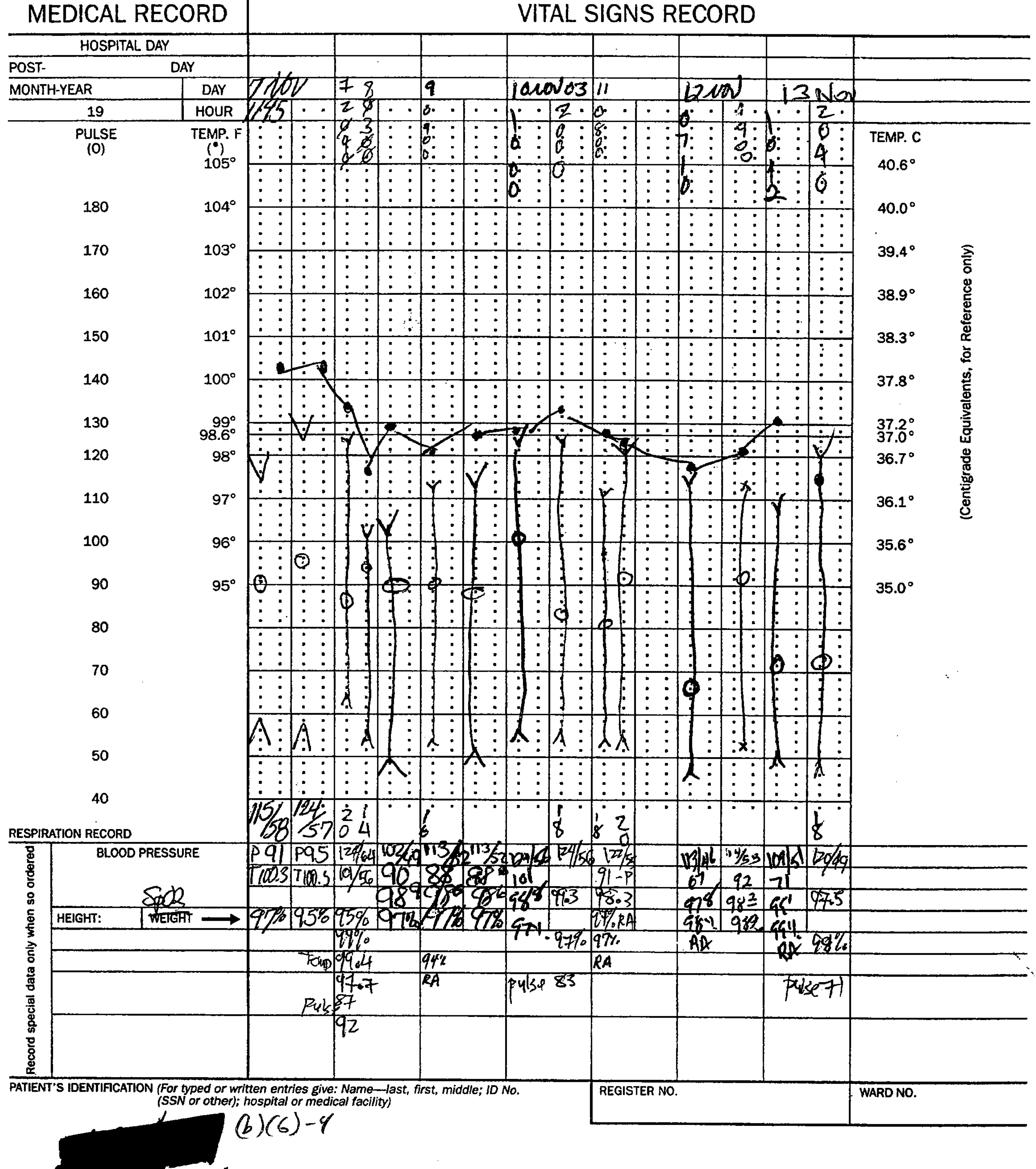
(b)(6)-4

STANDARD FORM 511 (REV. 7–95) BACK

MEDCOM - 23236

MEDICAL RECORD

VITAL SIGNS RECORD



HOSPITAL DAY
POST- DAY
MONTH-YEAR DAY
19 HOUR
PULSE (O) TEMP. F (•) TEMP. C
RESPIRATION RECORD
BLOOD PRESSURE
HEIGHT: WEIGHT
Record special data only when so ordered
(Centigrade Equivalents, for Reference only)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

(b)(6)-4

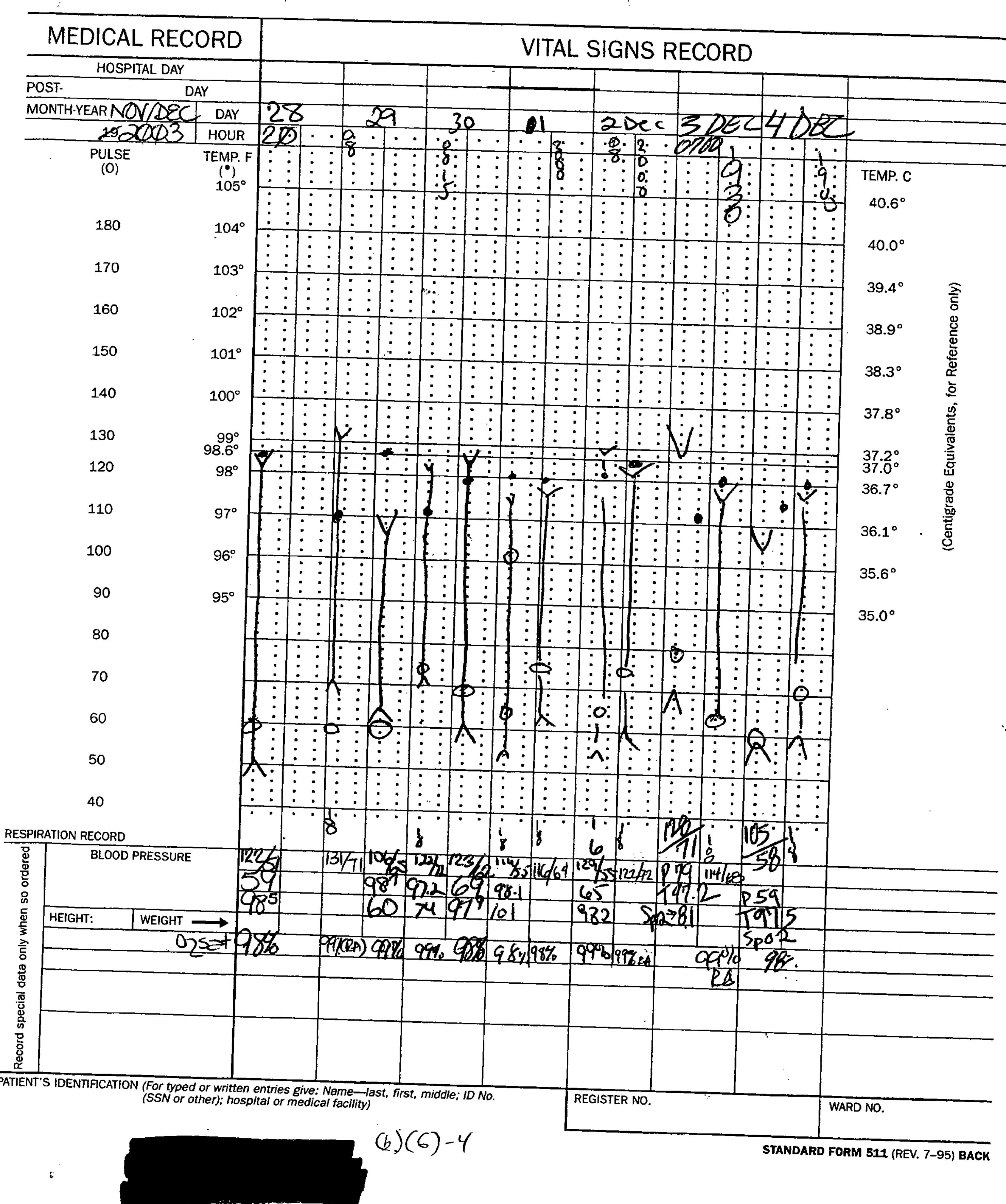
REGISTER NO.

WARD NO.

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
Prescribed by GSA/ICMR, FIRMR (41 CFR) 201-9.202-1



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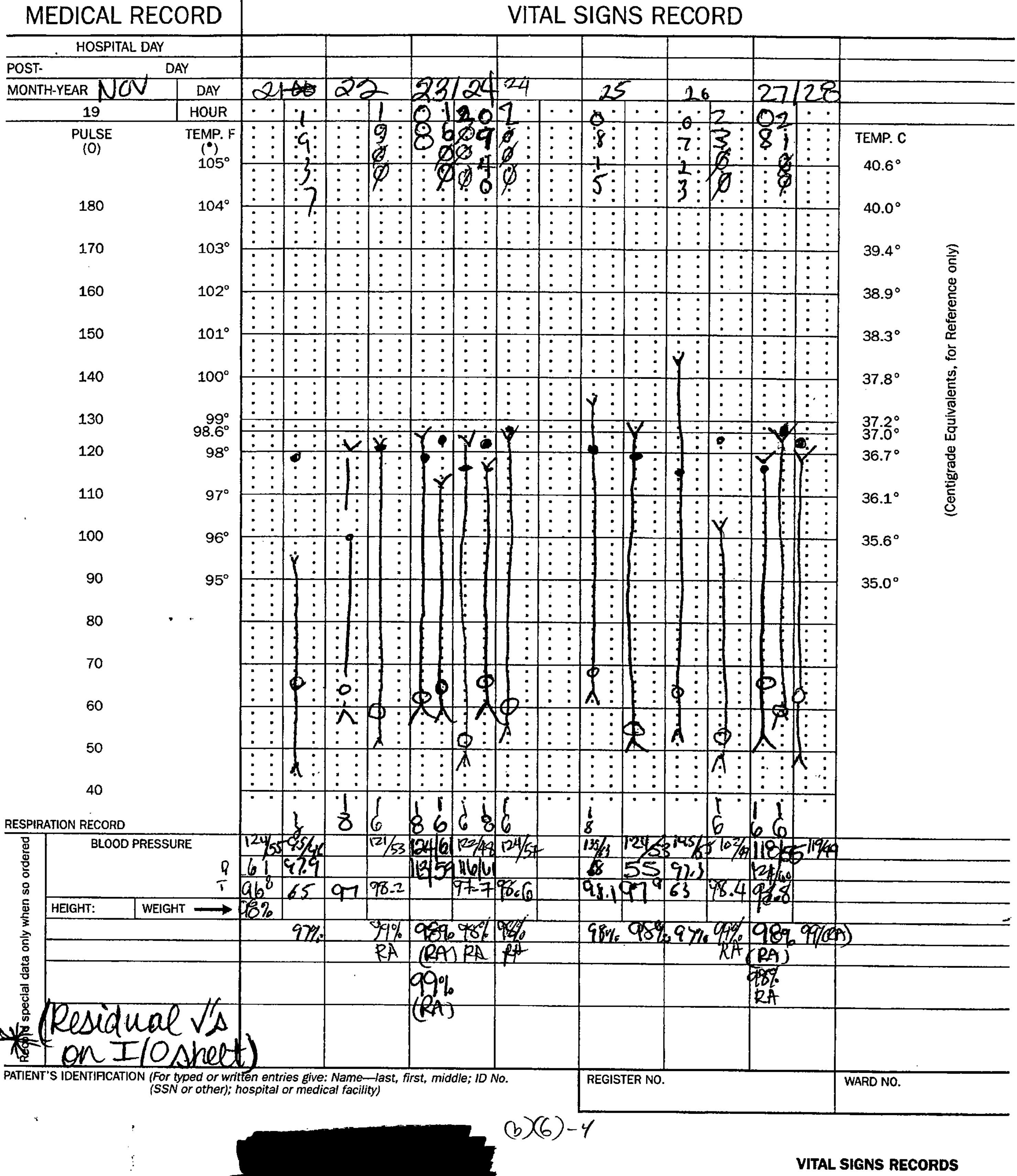
DOD-036815



MEDICAL RECORD — VITAL SIGNS RECORD

HOSPITAL DAY
POST- DAY
MONTH-YEAR NOV DAY 21 22 23/24 24 25 26 27/28
19 HOUR

PULSE (O) / TEMP. F (•) / TEMP. C
180 104° 40.0°
170 103° 39.4°
160 102° 38.9°
150 101° 38.3°
140 100° 37.8°
130 99° 98.6° 37.2° 37.0°
120 98° 36.7°
110 97° 36.1°
100 96° 35.6°
90 95° 35.0°
80
70
60
50
40

(Centigrade Equivalents, for Reference only)

RESPIRATION RECORD
BLOOD PRESSURE
HEIGHT: WEIGHT

Record special data only when so ordered

*(Residual V's on I/O sheet)

PATIENT'S IDENTIFICATION (For typed or written entries give: Name—last, first, middle; ID No. (SSN or other); hospital or medical facility)

REGISTER NO.

WARD NO.

(b)(6)-4

VITAL SIGNS RECORDS

Medical Record

STANDARD FORM 511 (REV. 7-95)
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MEDCOM - 23239

Ward/Section: OR | REQUESTING PHYSICIAN

LAST, FIRST, MI. [redacted] (b)(6)-4 | DATE 12Nov | TIME | SSN/PSEUDO SSN:

LABORATORY RESULT FORM
(Subject to the Privacy Act of 1974)

(Hematology) CBC

TEST	RESULT	REF. RANGE
WBC		4.8-10.8 x 10³
RBC		4.7-6.1 x 10⁶
Hgb		14-18 g/dl (M) 12-16 g/dl (F)
Hct		42-52% (M) 37-47% (F)
MCV		80-94 fl (M) 81-99 fl (F)
Plt		130-500 x 10³ verified
Lymph %		20.5-51.1%

(Hematology) Manual Differential

Segs		Mono	
Bands		Eos	
Lymph		Baso	
Atyp		Imm	
RBC Morph			

Spun Hematocrit		42-52% (M) 37-47% (F)
Sed Rate		
Other		

Urinalysis

TEST	RESULT	REF. RANGE
Color		N/A
App		N/A
Glu		Negative
Bili		Negative
Ket		Negative
SG		N/A
Bld		Negative
pH		N/A
Prot		Negative
Urob		0.2-1.0
Nit		Negative
Leuk		Negative
HCG		Negative

Misc. Serology

TEST	RESULT	REF. RANGE
RPR		Negative
Mono		Negative

Microbiology

Source		
Gram Stain		
Occ Bld		Negative
H. pylori		Negative
Micro Parasites		
Malaria		
O & P		
Other		

Microscopic Urinalysis

CSF

Cell Count		
Directigen		Negative

Blood Bank

MUST SUBMIT SF 518 WITH EVERY UNIT REQUESTED

ABO/Rh

Coagulation Studies

TEST	RESULT	REF. RANGE
PT		9.8-13.6 secs
APTT		21-34 secs
D dimer		<20 ug/ml
FDP		<10 ug/ml

Blood Bank Unit Crossmatch
(MUST SUBMIT SF 518 WITH EVERY UNIT OF BLOOD REQUESTED)

UNIT	TYPE	CROSSMATCH

REMARKS:

REPORTED BY: | DATE: | LAB ID NO.:

MEDCOM - 23240

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DOD-036817